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ORIGINAL ARTICLES.

CONCERNING THE TREATMENT OF CLUB-FOOT*.

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The conclusions of this paper are based on private and public work done during the last ten years, during which period I have seen and treated over five hundred cases of club-foot. The term club-foot is used here to embrace all varieties of foot-deformity. No adequate reason for limiting the term to the single variety of *talipes equino-varus* has thus far been presented.

The treatment of club-foot may be entirely mechanical, or both mechanical and operative. Prior to the commencement of the present century all remedial efforts were strictly mechanical. The result in the majority of cases was but a partial cure, obtained at great expense of time and patience to both patient and physician. It is common knowledge that, after many months of mechanical treatment by Sheldrake, Lord Byron became disgusted and abandoned further curative attempts.

With the introduction of tenotomy, mechanical appliances were almost entirely set aside in practice, and again partial cure became the rule. Quite re-

cently, with the advent of clean surgery, and with the intelligent employment of both mechanical and operative measures for relief, the treatment of club-foot has reached a rational basis. To-day, when cases are seen sufficiently early, few surgical procedures are as exact in indication or as certain in result as the methods for rectifying club-foot.

The initial step, in correcting any congenital club-foot, is to adopt, at birth, the mechanical plan of treatment necessary to bring about either a complete, or, when this is impossible, a partial cure. If only a partial cure obtains, the appliances, while aiding to accomplish this, have entirely prevented increase of deformity, which without their use would have ensued; and also, the surgeon has thereby been enabled to await the arrival of the proper time for operative interference. Mechanical correction may be effected by the hands; by elastic and other bands; by plaster of Paris and other stiff materials; by various shoes, splints and steel mechanisms, or by leverage, called by some "forced" correction. The selection of a mechanical method of cure, in any

* Read before the Philadelphia County Medical Society, January 13, 1897.

case, is largely determined by parental intelligence, accessibility and physical condition of the patient and by the degree and stubbornness of the deformity. Some feet can be straightened by manual effort alone; others, during their course of treatment, will require, along with manipulation, suitable retentive apparatus. The various appliances and their right usage are so well understood and agreed to that they will not be considered at greater length. It is, however, very important that the physician, after a careful study of the case, should decide for himself what apparatus is necessary to a cure. It is just as improper for the instrument-maker to determine the mechanical treatment of a case as it is for him to select and direct operative measures. Frequently the instrument maker, for the time being a self-constituted physician, will prescribe, *e. g.*, for an active tuberculous arthritis a brace that affords free motion to the joint and a splendid opportunity for amputation at a little later period.

Many club-feet are not seen by the surgeon until the deformity is so fixed, so unyielding that both mechanical and operative interference are requisite for a cure. In this article I shall devote greater attention to operative than to mechanical measures, because the injudicious choice of operative procedure may render an operable foot entirely unoperable—a very serious error, which the inconsiderate selection of apparatus could hardly bring about.

Perhaps a clearer understanding of this part of the subject will be secured by discussing the questions: At what age is it best to operate? Shall the operation be open, irrespective of the removal or non-removal of bone, or shall it be subcutaneous? and, What is the post-operative treatment of club-foot?

I believe that no *congenital club-foot* should be operated on until the child has learned to walk, *i. e.*, usually from the twelfth to the twentieth month after birth. With skilful manipulation, and, if necessary, retentive apparatus, many cures can be effected when there is slight deformity. Severe cases, however, require, beside operation, mechanical treatment, both previous and subsequent thereto.

Some children with club-foot are not of robust build and may become victims to one or other of the maladies of infancy, and thus early operations may be rendered useless. Why add shock from operation and anesthetic to the already too long gauntlet of children's enemies? Mechanical treatment, judiciously selected and applied, will never cause death. An operation, however skilfully performed, may be "the last straw" under which the little one sinks into an early grave.

When a child can walk, in addition to suitable apparatus, its body-weight very materially contributes to the retention of the foot in its correct position. A pressure of from fifteen to thirty pounds controlled by mechanisms, constantly acting while the patient stands erect, is without doubt a powerful corrective agent. Further, it must not be forgotten that many cases are assisted to a cure by properly directed muscular action. The infant's foot is so small and the tissues are so tender that often with operations done too early, unless the surgeon can frequently see the part, and the parents are more painstaking and intelligent than usual, it is very difficult to avoid either partial or complete relapse, even when apparatus is worn. The failures, one excepted, that I have witnessed resulted from operating too early or from neglect of treatment, or they occurred when open section was done. In the excepted case a concurrent scarlet fever—which began a day or two after operation—necessitated the cessation of further efforts to correct the club-foot.

Shall the operation be *open*, with or without removal of bone, or *subcutaneous*? Krauss, Wolff, Bradford, Lovett, Lorenz, Young, Lewis and Reginald Sayre, Allis and others affirm that any club-foot needing operative measures for its correction, in child or adult, can be rectified by subcutaneous section of the soft tissues, aided by force and proper retentive appliances. This is a strong and, as I believe it to be, a correct statement.

I will quote from H. A. Wilson's paper¹ on "Bone-operations for the Correction of Club-foot":

¹ Reprint from the Transactions of the American Orthopedic Association, September, 1893.

Shaffer, replying to the question, How many bone-operations have you performed for the cure of club-foot? says: "If your query was 'How many cases have you had which have been condemned to osteotomy and which you have cured without operation?' I could give you some statistics."

Lorenz says: "I consider every bone-operation, in club-foot, as a mutilation of the foot and as a criminal act to the practice."

Lewis Sayre writes: "I have seen only two cases which I could not correct without this procedure. I gave one of these cases to Dr. Stephen Smith and the other to Dr. E. Mason. One had amputation done subsequently, and the other died of septicemia."

Wilson remarks, in the paper before mentioned: "I have been unable to ascertain the grounds for selecting bone-operations in preference to other well-known and equally reliable procedures prior to the age of eight and twelve years, at which time it is presumed that the bones of the foot are firmly ossified and unyielding." Again he says: "A very large majority, if not all," cases of club-foot "could be corrected by soft-structure section, either with manual or mechanical stretching and tearing and proper post-operative treatment."

Many orthopedic surgeons, who, when they deem it necessary, operate upon the soft structures by open section, strongly condemn the removal of bone except in the rare cases in which other methods have failed.

Willard, replying to a personal question, said: "My typical results are secured in those cases corrected without the removal of bone, and I find it unnecessary to remove any bone except in cases in which the dislocated head of the astragalus is too large to be returned to its normal position. The dimensions of the bone are readily determined on exposing the foot to the X rays."

It is certainly a mistake to say that the bones will not yield to "forced correction," after the twelfth year, for the ages of many of the most marked and stubborn cases of deformity, in my experience, varied from the twelfth to the twenty-fifth year, and in straightening such feet the bones were literally molded into the desired position.

Krauss says: "(1) The different methods of resection of the tarsus impair the form of the foot and the stability of its osseous arch, with a consequent impairment of mobility and usefulness; (2) Resection as an operation is not free from risk; (3) The extirpation of the astragalus is a more suitable operation for restoring the form of the foot than the removal of a wedge in the direction of the medio-tarsal joint; but it leaves an immovable ankle, or one partly so, a weak union between the os calcis and the second row of tarsal bones, and serious shortening of the foot; (4) Resection removes all chance of future restoration by orthopedic treatment; (5) There is no conceivable form of club foot in which tarsal resection is justifiable, except it be in the case of one that is persistently painful in an old subject and in which there is no possible prospect of a good result from orthopedic treatment. In such a case resection may be fairly tried instead of amputation."

Hence, with quite divergent views as to the best plan for dividing the soft tissues of the foot, there is general agreement among orthopedic surgeons against the removal of bone.

It is not asserted here that open tenotomies and operations such as Phelps', or any of the seven methods of tarsal excision, will not straighten club-foot; but it is believed that the section of the soft tissues can be accomplished with less risk of sepsis, less mutilation of the foot, less pain to the patient, without any exposed cicatrices and with greatly decreased post-operative contraction; thus insuring, if these claims be just, a stronger, more shapely and more useful foot than is obtained by open operations. I have experienced no difficulty from inability to identify structures beneath the skin, from failure of tendons to unite, or from loss of time. Nor have I seen a single case of sepsis in subcutaneous operations for club-foot. Any surgeon who neglects strict aseptic precautions is incompetent to operate on a club-foot or anything else. It is far more likely that sepsis will occur in a Phelps operation, in which a large wound is left open to granulate and the clot to organize, than that septic matter will enter the tissues through a

minute opening in the skin which will close and practically heal in twenty-four hours.

I have not infrequently seen infection occur in open wounds, when for relief from pain and in order to control the septic process, it became necessary to remove all restraining apparatus: and the result was the return of the foot into a position less useful, more deformed and less operable than before treatment was instituted. When sepsis appears in a wound, after subcutaneous operation, it is just as readily opened and cleansed as is an open section, which—owing to post-operative symptoms—must, after having been sutured, be reopened. *Does not every single wound that is thus sutured really become a subcutaneous operation?*

That there is less mutilation of the foot through operating subcutaneously needs no discussion. No bone is removed, the skin and immediately subjacent tissues are not divided—so that, from the very nature of the case, the statement is true. Pain, after subcutaneous section, is infrequent, and when present is due mostly to pressure of restraining appliances. Of course, in subcutaneous sections, there are no tender and exposed cicatrices; they can exist only after open divisions. It is impossible to have such contractions as follow open operations because the skin and next underlying structures are not divided in subcutaneous procedures. Phelps severs all structures down to the bone, and others remove more or less bone. Such destruction and mutilation never take place by the subcutaneous method of treatment, and they are cruelly, unscientifically and needlessly inflicted in open plans of correction.

It is not difficult to identify, subcutaneously, structures requiring division; their names do not assist the competent operator to correct a deformed foot. Any soft structure maintaining the deformity must be divided by cutting and tearing, or be sufficiently elongated by stretching.

Only once have I seen an important vessel severed. The resulting hematoma told what had happened. The tumor was opened by Dr. Allis, whom I was assisting, the clot removed and the bleeding vessel was ligated. The wound

was immediately sutured and the restraining apparatus was re-applied. The patient made an uninterrupted recovery and had a perfect correction of the foot.

Not a single tendon has failed to unite in any of my cases, and with properly instituted treatment such an accident must be very rare.

Subcutaneous operations do not require so much time for their performance, nor is their post-operative treatment so difficult or so extended as when open section is practised.

At infrequent times it is necessary to shorten a tendon. It is scarcely necessary to say that this must be done by open section.

What is the post-operative treatment of club-foot? Following operation, fixation of the foot in an over-corrected position should be maintained, for about six weeks, by means of plaster-of-Paris bandages applied from the toes to just below the knee. The foot is thus molded and forced into the required position, and the bones and soft structures all yield to the continuously acting pressure of the rigid dressing. The plaster of Paris should be removed weekly in order to inspect the foot; for if this precaution be neglected, serious injury from pressure may take place. When changing the plaster dressings, if the correction has not been ample, opportunity is afforded for anesthetizing the patient and using leverage for further correction of the deformity. This will be required in many severe deformities. Subsequent to treatment by "fixed" dressings a retaining shoe and brace must be worn. In marked deformities of children, the shoe and brace are worn until the child is twelve years of age; ossification is then completed. In adults the time will vary with the degree of deformity. After discarding apparatus, both children and adults should be kept under observation, and, if there is any tendency to a relapse, the supports should be at once reapplied.

"So you are looking for a situation?" said the lady at the door. "Yes'm," said the tramp, touching his hat. "What place did you last fill?" "Me stomach, ma'am," with another touch of the hat. —*Yonkers Statesman.*

SCIATICA.

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The term neuralgia is used to distinguish those functional affections of which pain is the chief characteristic. In a purely neuralgic disease there is neither inflammation nor any appreciable lesion in the painful part, but there is a condition of morbid sensibility.

Sciatica may occur abruptly, but in the great majority of cases there are premonitions, such as a sense of heat, a feeling of weight, or some uncomfortable feeling in the seat of the affection. The neuralgic pain is chiefly or exclusively in paroxysm, or there may be more or less continued pain with exacerbations, in which the pain is very much increased. The continual pain may be dull, but during the paroxysm it is darting, tearing, lancinating and excruciating. The paroxysms are of variable duration, some lasting only a few seconds, in other cases for several hours, days, and perhaps even years. The lancinating pain shoots in the direction of a nervous trunk and its branches, and patients sometimes delineate the track and distribution of the nerve affected in defining the directions in which the pain extends.

In the great majority of cases sciatica is unilateral. It ranks in frequency with intercostal and facial neuralgia. It occurs less often in the female than in the male, the relative proportion being as three to two. It seldom occurs before the age of twenty, and rarely after the age of sixty. It is sometimes symptomatic of pregnancy, of enlargement of the retro-peritoneal lymphatic glands, of accumulation of feces, or foreign substances in the sigmoid flexure of the colon, and of intra-pelvic tumors; but in the great majority of cases it is a functional affection. Tenderness on pressure, limited to circumscribed points, is an important diagnostic feature, and these tender points will be found where the nervous trunks or branches emerge from the spinal canal; over branches which penetrate muscles on their way to the integument; at the

termination of branches which are lost on the surface, and in places over the trunk near the surface.

Pain may not be produced by pressure with the open hand or palm; and, indeed, firm pressure thus made often relieves the pain. The tenderness is shown by pressure made with the ends of the fingers along the track or by percussion. The pain is often very acute and so limited that the space can be covered with the end of the finger. The character of the pain is sometimes described as burning, and at others as a sensation of coldness. The patient feels as if a current of hot or cold liquid was flowing in the course of the affected part.

The painful and tender points are to be found on the sacrum, over the sacro-iliac junction, about the middle of the crest of the ilium, at the sciatic notch, between the trochanter major and the tuber ischii, on the thigh along the track of the nerve, in the popliteal space, on the border of the patella, over the articulation of the fibula with the tibia, where the nerve passes around the fibula, over the lower and posterior part of the external malleolus, on the dorsum of the feet and the outer portion of the soles.

Sciatica rarely, as compared especially with facial neuralgia, exemplifies in the recurrence of paroxysms the law of periodicity. Like other neuralgia, its duration is very variable. As a rule, in favorable cases it persists for several weeks, disappearing as it developed, in most cases, gradually. In the vast majority of cases sooner or later it ends in recovery, but in some it continues indefinitely in spite of all remedial measures. Sometimes the pain is so severe that the patient is rendered in completely paralyzed for a time.

The diagnosis involves its discrimination from muscular rheumatism, and from the affection of the hip-joint commonly known as morbus coxarius.

Muscular rheumatism differs from neuralgia in the limitation of pain to the

affected muscles, in the diffusion of tenderness over a considerable space corresponding to the number of muscles affected, and in the fact that paroxysms of pain are excited exclusively by movements of the affected muscles.

Morbus coxarius is distinguished by the pain in the hip-joint produced by pressure on the great trochanter and by flexion and extension of the thigh; moreover, febrile movements, general debility, emaciation, etc., in conjunction with the local symptoms point to chronic inflammation within the joint.

Anesthesia, muscular weakness, and varices in quite a number of cases are associated with sciatica. Tuttle reports a case as being due to an osteo-sarcoma of the ilium. It has been in several cases associated with the stigmata of hysteria, and after relieving the hysterical symptoms the neuralgic affection was also cured. In quite a number of cases there will be an absence of knee-jerk. This usually will serve as a criterion in the most severe cases, although sharp attacks will be experienced without the loss of the knee-jerk. Polyuria frequently occurs, due perhaps to an increase in arterial tension consecutive to morbid excitation of the sciatic nerve, or general arterio-sclerosis, and even to the beginning of venous sclerosis.

The rational treatment consists in the first place in fulfilling indications which relate to morbid conditions suspected to stand in a causative relation to neuralgia; for instance, malaria or lead poisoning. Diathetic conditions, especially rheumatism and gout, also anemia, which may be detected by the venous hum in the neck, otherwise not shown, claim appropriate measures. In severe paroxysms opiates are called for; even the risk of forming the habit at times must be incurred. Slight pain may be relieved by belladonna, hyoscyamus, stramonium, conium, chlorodyne, and tincture of aconite. Aconite, chloroform, opium, belladonna, stramonium, veratria and aconitia, applied in the form of ointments or liniments may afford relief.

The empirical treatment consists in using such remedies as have proved curative, such as methodic counter-irritation, either actual cautery, small blisters over the tender points and for quickness of vesication, strong water of

ammonia or a hammer heated in hot water or by firing or sinapisms. Electricity has great therapeutic power in many cases.

Of the general remedies each is only applicable to certain suspected cases; quinia, precipitated carbonate of iron, the ammonium salts (the hydrochlorate, nitrate and valerianate) at times seem useful. Of the zinc salts the valerianate takes the lead. Strychnia is sometimes beneficial. Potassium iodid is to be given to some. Hypodermatic injections of different medicines are claimed to be of benefit when injected in the course of the nerve, such as chloroform (pure), ichthyol and osmic acid in solutions.

R
 Osmic acid parts 5
 Glycerin " 40
 Aqua pure " 60
 M. Sig.—Five drops as an injection.

R
 Ichthyol parts 3
 Aqua pure " 100
 M. Sig.—Seven to thirty minims as an injection.

Morton, of Philadelphia, removed from a patient forty-five years of age, a tumor situated within the sheath of the great sciatic nerve at the upper boundary of the popliteal space, just where the nerve emerges from beneath the biceps muscle. It was about the size of a large turkey's egg, with the fibres of the nerve partially spread out on the growth, the tumor being separately enclosed in a capsule within the sheath. The wound was closed without drainage. For three days there was considerable pain along the whole track of the distribution of the nerve, after which all pain ceased and the man was cured. Potter advocates nerve stretching.

Professor Huxley's widow has been granted a civil list pension of £200 a year as a recognition of her husband's services. The *Medical Press*, commenting on this, says: It affords subject for reflection that in this wealthy country the man who contributes more largely to the welfare of the community than a wilderness of millionaire brewers or stock speculators, receives so little thanks of a material kind that he has to leave his widow to the mercy of a system which rewards his labors with a pitiful £200 a year."—*The American Practitioner and News, London Letter.*

THE RADICAL OPERATION FOR CANCER OF THE BREAST.

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Excision of the mammary gland for malignant tumors is a very unsatisfactory operation, not so much on account of the technic, which is simple, but on account of a recurrence of the growth in 95 per cent. of all cases treated under the old plan. Amputation of the breast is a useless and unjustifiable procedure; the unavoidable manipulation of the tumor during the removal of the breast under the ordinary method is responsible for the entrance of cancerous matter into the healthy tissues of a fresh wound, thus favoring a recurrence locally or metastasis to the internal organs.

In order to diminish mortality, to prevent a recurrence as much as possible and to increase the rate of recoveries, Kuster, Halstead, Meyer, Bull and other surgeons have recommended the extirpation of the breast with the pectoralis major, if necessary, with a thorough ablation of all the contents of the axilla, saving only vessels and nerves. This is called the radical or complete operation. Under this method Bull claims 26 per cent. of recoveries, while Halstead, of Johns Hopkins Hospital, publishes a report of 100 cases with ninety-seven recoveries, and only three recurrences, and the patients were under observation from six to eight years.

One year ago I was consulted by a colored woman, aged fifty-five, married, the mother of several children, for a painful tumor in her breast. The patient was emaciated and complained of lancinating pains, especially at night, which deprived her of her accustomed rest. The tumor was of one year's duration and had been preceded by an eczematous rash. Upon examination I found retraction of the nipple and above it a hard tumor the size of a small orange, while upon the top of the same the skin was broken, emitting a foul-smelling discharge. The axillary glands were very much enlarged and indurated. My diagnosis was carcinoma of the breast.

After two weeks of preparatory treatment, I operated. The long incision was with one sweep of the knife and well carried up on the arm as far as the lower border of the teres major tendon. The costal insertions of the pectoralis major and the muscle with the breast were turned over under the arm by means of nothing but the fingers, in order to avoid a division of the cancerous tissue. All connective tissue was dissected down in one single layer, and with a few sweeps of the knife the whole mass was detached from its connections. The pectoralis minor looked healthy and was not disturbed. The axillary fat and all glands within reach were then removed; the latter were of the size of large marbles.

This operation lasted nearly two hours on account of suspended respiration from chloroform. One week after, the patient was able to walk about, and in a few weeks more was well. I examined her recently and found her in good health; she had good use of her arm, the cicatrix is soft, and there is no point of induration; and while the woman has not yet passed the three years' limit, I am still hopeful of her recovery. This operation is surrounded by many difficulties. It is a major operation, but the only one that holds out any reasonable prospect of success. It is attended with but little more risk than the ordinary method, and the mortality ought not to exceed two or three per cent., but in no case should operative treatment be delayed.

"Look here," said the irate departing guest from a Florida winter resort, "when I came here you told me that the charge would be \$3 a day. Now you present a bill of \$36 for six days! How do you figure that out?" "That is quite right, sir," replied the clerk. "The rate is \$3 per day and the same per night. You were here at night, also, were you not?"—*Pittsburgh Chronicle Telegraph*.

THE PHYSICIAN AND THE TOBACCO HABIT.*

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I was taught and still believe that medicine is a sacred calling, that it combines in itself the excellences of all professions and that the physician is, or ought to be, a man set apart and devoted to the betterment of the various interests of humanity, since the broad study of medicine considers man morally as well as physically and includes within its sphere the issues of life and death. As law concerns itself with man's constitutional and other rights, and theology with his relation to God, or if you prefer it to good, and to his fellow-men, so medicine has to do not only with these but also with the health and indirectly with the morals of the community, since these are so inseparably associated with a sound body that often bad morals to the physician simply means bad health.

With this lofty conception of the duties that belong to our exalted mission, this implied necessity on our part, transmitted, perhaps, from the Greek priest-physicians, not only to avoid vice itself, but also the very appearance of evil, this positive duty devolving upon us to separate ourselves from and condemn everything that causes either moral or physical deterioration, you may imagine the sorrow that possessed many of the alumni of our common *alma mater* when they realized that this association called by her name had gone over to the Philistines, and had deliberately decided and officially announced its purpose to give the weight of its example in favor of an indulgence condemned by so many familiar with its evil effects.

It seemed just cause for grief that a body of thinking men, recognized custodians of the public health, had stamped with their approval a custom opposed to health, one that has become the bane of domestic and public ethics as well as of esthetics, a menace to the

higher education, often an enemy of moral reform, and a cause of mental decay; a habit that has frequently caused an obliteration of that faculty which enables man to recognize the rights of others. That we, an association of physicians, should have deliberately decided to encourage this procreator of disease, this originator of an appetite for strong drink, this habit which, according to the conviction of many prominent educational and medical authorities, is the "worst curse of modern civilization" is indeed an anomaly of conduct calculated to make the judicious grieve.

I am not discussing the rights or the habits of the individual and presume not to limit the liberty of any man. I war with an association, if consent of the many is sanction for sin, deciding officially what is not only inconsistent and unseemly, but morally wrong. Since indulgence in tobacco mars the best in us and since its use is an offence against our better selves and those who do not use it, it is both a vice and an immorality. It should be considered in connection with man's duty to himself, to develop his better nature, and to suppress what is base.

Anything diminishing without adequate return the progress-evoking quality in man is morally wrong. Yet a chief claim for the use of tobacco is that it causes ease of mind, stifles desire for action. If our forefathers had been content with the tyranny of an alien, they would never have declared themselves free. Asia was conquered by Athens and Greece by Rome, and the civilization of beyond the sea has been transmitted to us because of the discontent of the men who have gone before. And this divine discontent the narcotic weed will benumb! West Point rejects the users of tobacco and the better colleges refuse them. They seldom are successful in either physical or mental lines, and often have a stunted development. But what care they? Like the

* Read at the Boston Supper given by the Philadelphia Alumni Society of the Medical Department of the University of Pennsylvania, September, 1896.

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lotus eaters in the Homeric legend they have eaten of the enchanted fruit, and are content to live in effortless idleness.

"The Tobacco Problem," a book on the subject by Mrs. Lawrence says: "The evil of tobacco exceeds that of drink. Smoking stupefies the student into dull obliviousness. Tobacco soothes the excited nerves to render them ultimately more irritable. The tobacco vice is a nerve-ending gnawing that will not be denied and under the guise of absolute physical necessity hides its cruel demands. The drug produces debility in self restraint and weakens the power of the will; it impairs physical vigor, perverts the taste, diminishes mental capacity, corrupts the moral sense, and stimulates the animal nature. It is the cause of inferior scholarship among our students, and takes away the sense of shame in failure. The free use of tobacco is undermining the health and weakening the will of the present generation, and is as noxious as the giant evil, drunkenness. There are students, even clergymen, whose usefulness has been as thoroughly ruined by tobacco as it could have been by drink. The tobacco habit gains ground at the expense of emotional refinement and spiritual force. More young men break down in body and mind and go astray as a result of smoking than as a result of drinking."

Thus by indulgence in the debilitating solace of the weed, the power of achievement is weakened, and men handicap themselves in the struggle where only the fittest survive. The demoralizing effect of the omnipresent vice enters every avenue of life. The respectable laboring man and his family has no greater enemy than tobacco. He returns from the work of the day with a pittance only sufficient for bread, to find the larder empty, children half clad, the rent unpaid and the wife worn out with the overwhelming perplexities of the day. Home and its misery present a spectacle that appeals to his better nature. He is a religious man, perhaps, yet with scruples against beer, but there on his mantel lies a pipe black with the stains of long usage, and soon, under the spell of its influence, what does he care for the misery of his condition or what

desire has he for the betterment of his state? Would it not be better, more manly, more courageous, to fight the ills we have with clean minds and steady nerves, than to resort to the drug that moralists tell us often makes man selfish and unmannerly and sometimes worse?

The opium eater does not compel you to eat opium; the drunkard does not oblige you to drink; but the slave of the tobacco vice, because of regardlessness of your rights, compels you to participate, by causing you to breathe the smoke he has just discharged from his own mouth. Is not this an infringement of the rights of others to breathe pure air? Is it not an inconsistency for the man practicing homeopathy on himself to find fault with those who only practice it on others? Is it not an immorality for a man by indulgence to produce a disease for which he must constantly supply a remedy? Yet the man who tries to secure calmness of mind by the use of tobacco certainly believes *similia similibus curantur* inasmuch as he attempts to cure his disease by the thing that caused it.

Coleridge's axiom that "every educated man ought to know all the best things," has almost become an axiom. If this applies, as it unquestionably does, to the ordinary gentleman, it does so with double force to the physician, for he needs to be a man of deep endowments, requiring a wide extent of knowledge for the proper practice of his profession. As a gentleman, associating with the most polished and best-trained members of the community, he certainly needs to be "acquainted with the best things." We cannot do our entire duty often because of unpopularity, and what causes this unpopularity more than the frivolous ostentation of narrow endowments? Yet how can any man, however limited his horizon, with the only thing quick about him his temper, feel sufficiently dissatisfied with his own acquirements as to cause the accomplishment of Coleridge's dictum, who carries in his pocket a drug that will produce content when he ought to be miserable and ashamed! The books of Nature's inspiration and achievement are equally sealed to many men, because that with a cigar in their mouths and a tawdry

newspaper in their hands they are content to be unacquainted with "best things," while they float with the tide on the vapor of a cigar.

Are there not men of good purpose in the profession who do not know a single language but their vernacular, and, like the Mesgites of Homer, do not know that right, who are utterly unacquainted with those universal tongues, painting and music; familiar with but little about the history of their own compassionate art; not aware that the man is better than his drugs; who do not even perceive, as Professor Cross once said, that "the doctors who know nothing but medicine do not know that;" and yet, without being acquainted with the best things, are content? Or, if they do occasionally realize a deficiency in certain directions, instead of allowing di-

vine discontent to inspire repair, light a cigar or take a bite from a mass of talismanic material they carry in their inside pocket, coerce the reward, omit the work, and presto! they "are Sir Oracle," and when "they ope their mouths let no dog bark." Is not this a minor immorality, especially on the part of the younger men, presumably self-reliant and strong? Yet some are tobacco voluptuaries at twenty-five with the more exalted pleasures unknown and blotted out by an extrinsic solace tediously drawn from a weed.

Is it not an immorality to cloud the mind, already contemplative enough, by such a bourgeois indulgence in a narcotic that "weakens the memory and vitiates the appetite for proper food, produces vertigo and enfeebles the action of the heart?"

CURRENT LITERATURE CONDENSED.

Causes Leading to Tubercular Infection.¹

About one-fourth of the deaths from septic diseases in the United States result from tuberculosis of the lungs. Wherever civilized communities are found, and human beings remain settled in one place for any length of time, there the infectious microbe which causes this disease finds its way. Tuberculosis has become almost a household disease in many communities, and thousands of families throughout the country have their tubercular member, who is endangering the health of the others in the household. It is a very rare occurrence for a child to be born tubercular, even when the parents are so, although many come into the world with a strong tendency in that direction; that is, they do not resist the disease well, and when exposed to the infection easily become diseased.

Such children are apt to become very rapidly infected during the first year of life, and especially during the second, third and fourth years. After they begin to play on the floor, they are almost continually in the dust-laden air. The little child naturally puts everything into its mouth; and when it drops its

toys or anything it has in its hand on the floor, it picks it up and puts it, all dust-laden, back into its mouth. If this dust happens to be full of dried and pulverized tubercular sputum, as it is apt to be in the home of the careless consumptive, the little one swallows the poison, and being already predisposed to the disease, it readily becomes infected with it.

The tubercular germ, when dried, will retain its vitality for many months, and be ready for development whenever it finds a suitable soil. The tubercular germ, fortunately, does not increase outside the bodies of men or animals; and when exposed to sunlight and moisture, its infecting properties are soon destroyed. When it is kept dry, and in darkness, however, neither heat nor cold seem to effect its vitality.

While this germ is always the source of the disease, there are certain causes which predispose to it, or fit the body for the germ to grow in it. Whatever tends to impair nutrition so weakens the structures of the body that the glands of the lungs and other organs soon become invaded. The great majority of cases of consumption and other tubercular disor-

¹Condensed for *Public Opinion* from *Good Health*.

ders are preceded by disease of the digestive organs. The patient's general health failing because the digestive organs do imperfect work, all the cells and tissues of the body become enfeebled, and unable to destroy the disease germs which may find an entrance into the body.

If the structures are healthy, these germs are soon destroyed, but if weakened by disease, the germs grow and multiply, until in time the body is destroyed. All chronic diseases, as valvular heart disease, Bright's disease of the kidneys, disease of the liver, and ailments of the digestive organs, are predisposing causes of tuberculosis. Intemperance both in eating and in the use of stimulants is also a very active agent in bringing about conditions conducive to this disease. Among the lower classes of the large cities, where intemperance, licentiousness, and kindred vices prevail, consumption of the lungs is a very common disorder; and poverty and want furnish most favorable conditions for the spread of the infection.

Overwork and want of sleep, sedentary occupations, and living and working in badly-ventilated shops, factories, and stores, where successive generations of consumptives have worked and expectorated on the floors, and the buildings have become thoroughly infected with the tubercular bacilli, are all conducive to the disease. Churches, theater buildings, lecture-halls, and club-rooms that have been used for many years, and were shut away from the sunlight, being seldom properly ventilated, furnish excellent hiding-places for tubercular and other disease germs.

But while all these conditions predispose to tuberculosis, the disease cannot really exist without the germ which produces it. The ability to resist the disease is in proportion to the integrity and soundness of every tissue and organ of the body; therefore, whatever operates to destroy and lessen the number of germs in air, food and drink, and whatever leads to the promotion of general good health, will tend to finally stamp out the great plague of consumption.

The Signs of Longevity.¹

Every one is interested in the question of long life as applied to himself, and all

facts bearing on it are noted with becoming feelings of self-congratulation or otherwise. It is the staying power that is in demand, backed by an inherited and reserved vitality of resistance against the usual evils to which all flesh and other perishable things are subject. The law of heredity, which our life insurance companies understand so well, is at the bottom of all calculations as to whether a particular man or woman is wound up for seventy years or will run down at twenty or forty years. Aside from this testimony, there are certain physical qualities which have great weight in determining the result of the struggle against a conspiring environment. An oak has one configuration, and a cedar, pine, or mullein stalk another. It is the proper recognition of such distinctions that aids physicians in their prognosis and turns the balance against apparently desperate chances. At a recent meeting of the Academy of Science, F. W. Warner, in speaking upon the subject of biometry, offered some very interesting data, which are in the main true. He said:

Every person carries about with him the physical indications of his longevity. A long-lived person may be distinguished from a short-lived person at sight. In many instances a physician may look at the hand of a patient and tell whether he will live or die. In the vegetable as well as in the animal kingdom, each life takes its characteristics from the life from which it sprung. Among these inherited characteristics we find the capacity for continuing its life for a given length of time. This capacity for living we call the inherent or potential longevity. Under favorable conditions and environment, the individual should live out the potential longevity. With unfavorable conditions this longevity may be greatly decreased, but with a favorable environment the longevity of the person, the family, or the race may be increased.

Herein are presented the two leading considerations, always present and always interdependent—the inherited potentiality and the reactionary influences of environment. He continues:

The primary conditions of longevity are that the heart, lungs, and digestive organs, as well as the brain, should be large. If these organs are large, the trunk will be long and the limbs com-

¹ *Medical Record*, New York.

paratively short. The person will appear tall in sitting and short in standing. The hand will have a long and somewhat heavy palm and short fingers. The brain will be deeply seated, as shown by the orifice of the ear being low. The blue hazel or brown hazel eye, as showing an intermission of temperament, is a favorable indication. The nostrils being large, open, and free indicate large lungs. A pinched and half-closed nostril indicates small or weak lungs.

These are general points of distinction from those of short-lived tendencies, but, of course, subject to the usual individual exceptions. Still, it is well acknowledged that the characteristics noted are expressions of inherent potentiality which have been proven on the basis of abundant statistical evidence. Again, he says truly:

In the case of persons who have short-lived parentage on one side and long-lived on the other side, the question becomes more involved. It is shown in grafting and hybridizing that nature makes a supreme effort to pass the period of the shorter longevity and extend the life to the greater longevity. Any one who understands these weak and dangerous periods of life is forewarned and forearmed. It has been observed that the children of long-lived parents mature much later and are usually backward in their studies.

Such observations are of the highest importance.

The "Toilet" of the Nose.³

That the nose has been neglected by some people all the time, and by others most of the time, goes without saying. In many cases, even of quite annoying catarrh, the individual bears with and neglects it entirely. Not any mucous membrane that is exposed to atmospheric conditions, injuries or disease, resents morbid conditions so little, forcing the subject to the physician, as the nasal mucous membrane.

Let a foreign body lodge on the conjunctiva, or let there be an acute conjunctivitis, and the subject is forced to seek relief. Let the mouth become ulcerated, or let there be a carious tooth, and he is made constantly aware of his

trouble. Let the urethra become inflamed, and he will not tolerate it long before seeking assistance. Let him be troubled with hemorrhoids, and he is not content to bear his pain in silence.

But almost any disease of the nose is passed by unnoticed, traumatism alone seeming to be the most important cause for seeking advice. There must be some good reason for this neglect. It is not that the mucous membrane here is less susceptible to disease than elsewhere. It is probably the seat of inflammatory disorders more frequently than any other part of the body.

The patient bestows so little attention upon it because it does not, as a rule, cause physical pain, and often not even much discomfort. Mucous membranes throughout the body generally are more or less intimately connected with muscle-fibre, and are more or less constantly in motion, and any lesion existing will be stretched and kneaded and more or less pain will arise. But in the nose no such muscular action takes place, and the most intense inflammatory trouble may exist here, and the largest, foulest, most ragged ulcers, without causing any pain whatever.

It is not, therefore, a lack of sensory nerve distribution in the nose that accounts for absence of pain so much as that there is no mechanical condition present, such as muscular contraction and exercise by motion. The nose is rather a passive organ. Its two functions, as a respiratory organ and a special sense olfactory organ, are carried on in an almost passive manner.

Exposed to all kinds of odors, being a nidus for all kinds of fine detritus from organic and inorganic matter, with its own secretions infected and disorganized through contact with the great variety of matter to which it is exposed, notwithstanding its own disinfecting property, it is no wonder that acute and chronic disturbances are constantly met with. Being passive in action or function, it is naturally passive in its self-cleansive power, forcible expiration being necessary to rid it of accumulated secretion.

Careful attention is given all our other organs, and they, through their functions and muscular action, do much

³James H. Farber, M.D., Dayton, Ohio, in *Lancet-Clinic*.

towards cleansing and disinfecting themselves. But our nose is unable to cope with the mass of secretion and detritus that is constantly present, and sooner or later pathologic changes must take place. Not alone are the changes confined to the nose, but the ear, the pharynx, larynx and lungs, and the general system are in the direct line of this, the second "*prima via*."

It follows, then, that the long-neglected nose should have most careful attention. It should be as systematically cleansed as are the mouth, the teeth, the ears, the rectum, etc. In America, in all large cities and towns—and, for that matter, in every country—our streets are made receivers of all kinds of animal and vegetable matter, fresh and decayed, and this fine dust assails our nostrils from morning until night, laden with all sorts of bacilli and microbes and disease-germs.

It is therefore suggested that our noses should be prepared each morning for the exposure of the day. Let them be oiled up for their duties and strengthened to resist the deadly germs everywhere so prevalent.

The old Dobell's solution has been found most satisfactory of all for cleansing and disinfecting the nose. It should be used warm, and in small quantity only, each morning, to be followed by a very bland oil, such as liquid vaseline in small quantity. By such prophylactic measures our various forms of catarrh will disappear largely, and with them many other affections of contiguous cavities and structures, as well as promoting the general health. Even the sudden acute coryzas may be materially lessened in severity.

Medical Superstitions.⁴

In lieu of the large number of new remedies which have made their appearance during the last year, the following therapeutic hints taken from the *New York Press* have at least the merit of being very old and well known in former times, and in many cases were probably quite as efficacious as some of the more modern "cures." They are popular remedies in common use among the German peasantry.

The cures for epilepsy are especially varied, and are described as follows: To keep away epileptic fits, wear a thick silver ring on the finger, preferably one made from a coffin nail. In case of a "fit," open the clothing and scratch a cross on the breast with a needle, so that the blood comes, and lay a black cloth over the mouth. When one feels an attack of epilepsy coming on, he should look in a mirror, or smell of a bug of some sort.

Milk from a sow, blood from a weasel, a pregnant ass, seven drops of blood from the tail of a cat, or blood from a recently executed criminal, are all remedies for epilepsy.

For jaundice, drink water in which a gold piece has been kept for twenty-four hours, and shave the nose with a razor until the blood comes.

For malaria, chew the first violets of the season, eat apples Easter time, keep a three-colored cat in the house. Pass the fever over to someone else, if possible to an animal or plant, or bury it in the ground.

For ulcers, carry a nutmeg in the pocket.

For boils wear a gold piece, or a half of a hard-boiled egg, over the lesion.

To cure a felon, or "run around," hold the finger in a cat's ear for half an hour.

Cancer may be cured by applying fresh, warm hen's or pigeon's or calf's flesh.

For toothache, trim your finger-nails on Friday, eat bread a mouse has nibbled, or bury a tooth in the hole of a mouse, or carry in the pocket a tooth from a soldier killed in battle, or from a murdered man. Kiss a mule. Rub the gums with the body of an ant, bee or fly, or prick them with a sharp twig from a sweet apple-tree.

For ranula of the tongue, spit on a frog.

To cure a goitre, rub in oil from a lamp, especially from a lamp that has burned by a death-bed.

For gout, wear a copper ring, made from a coffin nail, or carry a snake skin, potatoes, chestnuts, or the tooth of a mole, or a dried toad.

For alcoholism, drown an eel in brandy and make the drunkard drink it.

For impotence, drink a glass of mother's milk.

⁴*American Medico-Surgical Bulletin.*

For stomach trouble, beer poured over a red-hot horse shoe is helpful.

For hydrophobia, inscribe upon a loaf of bread, on the upper crust, the following words, and give it to man or beast, as the case may require.

"Gerum heirum Lada frium hide thyself."

To cure warts, rub the wart with a potato and feed the potato to a pig.

If a child is puny and of low vitality, bore a hole in a young tree, at exactly the height of the child. Drive a plug into this hole, along with some hairs of the child's head. The belief is that as the tree continues to grow, so will the child.

Freckles may be removed by washing in water contained in a hollow stump, three successive mornings before sunrise.

Congenital Absence of the Ovaries With Rudimentary Uterus.⁵

The following case is of interest on account of its comparative rareness and as showing the necessity of making a most careful examination in every case of amenorrhea lasting for any considerable time.

The patient was a woman, aged twenty-three years, who had been married eight months. She consulted me in the early part of October, 1895, about the absence of menstruation. She had never menstruated, but when about thirteen years of age she had a violent stomach-ache, and her elder sister, thinking the pain to be premonitory to menstruation, gave her a heroic dose of pennyroyal, but without the desired effect.

Since then she had never had any of the symptoms usually present at or about the menstrual period. She had no desire for sexual intercourse and little, if any, feeling of pleasure during its performance. The breasts were moderately well developed, and, though rather slim, her figure was fairly well proportioned.

Her general health was good. She had never suffered from typhoid or other fever or from any acute disease, with the exception of a slight attack of influenza, about four years ago, and she had never had an accident of any kind.

My patient had consulted several medical men in her neighborhood without

obtaining much satisfaction. One told her "not to bother; she would be all right when she reached the age of twenty-one years;" another gave her a mixture containing iron, and directed her "to continue for a few weeks and she would be better," and so on.

On examination, I found the external genitals quite normal in appearance and the vagina, os, cervix, etc., to digital examination, and, as viewed with the speculum, also apparently normal, but bimanual palpation failed to map out the uterus or ovaries. I introduced a uterine probe through the cervix for an inch and a quarter and it refused to go further, the direction taken by it being that usually assumed by an anteverted uterus.

Thinking the obstruction to the further progress of the sound might be due to an acute antelexion, which I had not been able to distinguish by digital examination, I introduced, after heating and oiling, a No. 6 gum-elastic bougie, in the hope that it might pass any obstruction offered by an antelexion, but with the same result—i.e., it only passed for an inch and a quarter.

Examination *per vaginam* showed no trace of ovary on either side, and a careful and exhaustive examination *per rectum* yielded the same negative result. After having completed my examination, I expressed the opinion to my patient that she had no ovaries and only a rudimentary womb; that she would never menstruate, and that she could not possibly conceive, and proposed that she should see Dr. R. T. Smith, of Soho Hospital, to get a corroborative or other opinion. I informed Dr. Smith of the case, and she went as directed to be examined by him. He arrived at the same opinion as expressed by me, the only point of difference being that he thought the ovaries might be present, though in a rudimentary state as a result of arrested development.

In connection with this case, I would strongly advise that in all cases of continued amenorrhea a most careful examination should be made—and more especially in those cases in which the menstrual function has been unduly delayed or never occurred, and would strongly deprecate a routine practice of prescribing medicines prior to examination in the hope that good will result.

⁵ John Rutledge, M.D., *Aberd.*, in the *Lancet*.

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PHILADELPHIA, SATURDAY, FEBRUARY 6, 1897.

EDITORIAL.

THE PRACTICAL LIMITATIONS OF A SPECIALTY.

The specialist of to-day is essentially a self-made man, there being no method of insuring the possession of special skill, nor any legal or professional restrictions upon any one who chooses to announce himself as a specialist. Thus, so far as a specialty is concerned, the physician at the present time is as free from college or society supervision and as innocent of a diploma as might have been the general practitioner of several centuries ago. Under these circumstances, a man who calls himself a specialist cannot be considered as claiming superiority over his professional brethren, but merely as one who seeks to limit his practice from financial motives, or because he is conscious of certain proclivities and interests.

No man must stand quite so positively upon his professional merit as the specialist who observes the usual ethical rules of the medical fraternity. Only upon his office card does he appear as different from any other physician; if he gains a patient, it is for a limited time or a limited class of troubles, and the possible patronage of this patient extends to relatives and friends only as the latter happen to be afflicted with a like narrow range of ailments. Nor is any general practitioner so dependent on the good opinion and friendship of his colleagues as is the specialist.

It is universally conceded that, in return for the support which the specialist receives from the general practitioners, he should refrain from encroaching on

departments of medicine not his own. Herein lies one of the most embarrassing problems which the conscientious specialist has to solve. It has been seriously proposed to differentiate between "specialists" and "limitists;" but, in our opinion, a specialist is either a limitist or he is a fraud. In other words, no man should lay the slightest claim to being a specialist unless he intends to confine himself to the study and practice of one department of medicine. There is no objection to an informal understanding that A would rather treat surgical cases than medical, that B would like all the obstetric cases that he could attend, while C is disinclined to out-door practice, but from such mere prejudices and preferences, neither A, B nor C can properly be considered as a specialist.

Practically, however, it is hard to lay down arbitrary rules as to the limitation of practice, and our judgment must be rather in accordance with the spirit which a man manifests than with his literal fulfillment of a policy. In some specialties, which are well established and which are quite free from complications with other departments, the matter may be simple enough. In other instances, when the boundaries of a specialty are not established by precedent and when the practitioner has passed from general into special work, no absolute course of action can be planned in advance. We know a specialist who has been fully ten years in throwing off his general practice, yet no one can question his good faith nor his serious intention to devote himself to one field of work.

From personal experience, we realize how much the evolution from general practitioner to specialist depends upon external resources, upon personal influence and professional backing, nor do we believe that a would-be specialist is

required by any principle of ethics to drop the means of sustenance within his grasp for the sake of being free to seize what may be but the illusion of hope and ambition. In other words, the obligation between general practitioner and specialist is mutual. We would suggest that the proper course is first to refuse chance callers, then to turn over to the general practitioner families with whom the transitional specialist has had only a slight acquaintance; then to explain to one's more intimate clientele the customary limitations of practice, leaving them free to retain one's services or to seek advice elsewhere; finally to become more absolute in the refusal to take cases outside one's chosen work.

There are always left a few cases in which some especial personal consideration, such as the affection which often develops between patient and physician or the delicacy which many women feel at consulting a strange physician, claim the courtesy of the specialist and the leniency of his colleagues. We venture to assert that the well-supported legal right of the patient to choose a physician ought to take precedence over any merely business or ethical reasons for limiting practice.

As a matter of simple humanity, we believe that no physician should ever become so much of a specialist as to be unable or unwilling to render temporary aid in cases of emergency. Only recently we learned of an incident which bears closely on this point. A specialist refused to attend a man seized with some form of convulsions a short distance from his office, and another specialist, in spite of his limitation of practice, goes promptly when summoned. The laymen, acting as friends in need to the patient, are shocked at the indifference of the former physician and are disgusted with medical ethics when the latter attempts to defend his colleague

and to explain the general custom by which he was influenced.

We must confess that after making due allowance for the fact that convulsions are not usually immediately fatal, we believe that the lay opinion is the correct one. There are certain times of the day when it is almost impossible to find a general practitioner in his office, and these are hours when the specialist is usually at home. Why, then, is it not a matter of common sense, as well as of common humanity, for the latter to keep on hand a small emergency satchel, so that he may relieve pain, make at least a temporary surgical dressing, or assist a woman in labor, until the regular attendant or some available general practitioner may be found? So long as the specialist shows his good faith by not trying to keep every such case that accident throws in his way, why would not such a practice be conducive to the general welfare and efficacy of the medical profession?

The specialist is frequently called upon to decide whether a certain case belongs to him or not. Taking for granted the honesty of the specialist, we believe that such decisions should rest on symptomatic and therapeutic rather than on anatomic grounds. Thus, a man whose practice is almost entirely medical, should refuse a distinctly surgical case, even if the organ involved is classed within his specialty; and, conversely, the surgical specialist should follow his mechanical tastes and leave essentially medical matters to some one else.

Again, the limitations of a specialty should be according to natural lines and should be plain to the laity. A man practicing in such a way that he is obliged to be conversant with certain chemical, microscopic or ordinary physical methods of diagnosis, may with propriety be asked to turn his attention to

diseases outside his strict province, if the same technical skill is called into play. It is mere affectation for a man to say or to imply, "I can percuss a lung but not the heart," or "I can examine the urine in cases of suspected Bright's disease, but not to throw light on processes of digestion and absorption."

It must, then, be recognized that many cases belong equally to a number of specialists; that every specialist may occasionally turn his attention, at least for purely diagnostic or temporary therapeutic aid, to organs which he does not expect to treat in any great number; that the personal feelings of patients and the necessities of humanity may justify apparent inconsistencies. But, on the other hand, it ought to be equally plain that all these exceptions should make up a small part of the specialist's work and that his general policy should be such as to leave no ground for the charge, too often made, that he is taking every case he can lay his hands on, and is, in addition, attempting to pose as a specialist.

"Whatever one's calling," said Mr. Glimby, "there is nothing like a definite purpose to insure success. It has always seemed to me that a beggar who just asked in a general way for something simply fired in the air, and not at the target. Anybody can give an indefinite answer to an indefinite request, and most people do. But I met a man the other night who asked for two cents, at the same time holding out two cents which he already had and which he wished to increase to four. This was definite, business-like, and irresistible. I gave the two cents without the slightest hesitation.

"Still, this wouldn't work always. If the man had asked for a dollar, at the same time holding out another dollar, I should certainly not have given it, notwithstanding that this request would have possessed equally with the other the essential quality of definiteness. But then there are exceptions to all rules."—*New York Sun*.

CORRESPONDENCE.

DOMESTIC SANITATION.

EDITOR REPORTER:—In this age of rapid improvement in the arts and sciences, and of beneficial reforms in social and political life, it behooves physicians to contribute a share of time and talents in the promotion of the healthfulness of the community in which they reside. In their travels among patients they often see many existing evils that could be easily corrected were the attention of the public specifically directed to them.

In most farming communities there seems to prevail a careless indifference to anything that might tend to bettering their sanitary surroundings and a stubborn determination to ignore ways and means of important sanitary reforms. On some farms we find not only the stables and outhouses built in close proximity to the family dwelling, but overrunning with all manner of filthy accumulations. If a calf, sheep, or any other animal happens to die from accident or disease, the owner of such stock, after some hours' deliberation, takes his stoneboat, hitches his horse or oxen to it and after transferring the carcass of the dead animal to said vehicle drags it to a convenient distance from the house and there dumps it upon the ground. Here it is allowed to remain openly exposed to the air until it is converted into adipocere or until the crows constitute themselves scavengers *pro tem* and devour it.

How much better would it have been if the farmer had heaped a pile of straw and fagots on the dead animal, applied a torch and cremated it. But no!—that would have been too much trouble. It was so much better to allow the foul effluvia from it to contaminate the atmosphere for miles around. Sanitary laws should be enacted making it compulsory to cremate all refuse animal matter.

Allowing decaying vegetables to remain "*ad infinitum*" in dark and damp cellars is another source from which many diseases may generate. The im-

mediate removal of such matters and a generous sprinkling of chlorid of lime over the cellar floor would quickly remedy the difficulty and remove the cause of threatened infection. As an additional support to my theory of disinfection, I would suggest the liberal sprinkling of chlorid of lime in privy vaults, on stable floors and over the cellar bottoms once a month during the summer season and twice or three times through the winter season.

A. O. STIMPSON, M.D.

THOMPSON, PA., December 24, 1896.

The face is a good index to the state of one's physical being, and from it symptoms of disease can be detected almost before the patient is aware that anything serious is the matter with him. For instance, incomplete closure of the eyelids, rendering the whites of the eyes visible during sleep, is a symptom in all acute and chronic diseases of a severe type; it is also to be observed when rest is unsound for pain, wherever seated.

Twitching of the eyelids, associated with the oscillation of the eyeballs, or squinting, heralds the visit of convulsions.

Widening of the orifices of the nose, with movements of the nostrils to and fro, point to embarrassed breathing from disease of the lungs or their pleural investment.

Contraction of the brows indicates pain in the head, sharpness of the nostrils, pain in the chest, and a drawn upper lip, pain in the abdomen.

To make a general rule, it may be stated that the upper third of the face is altered in expression in affections of the brain, the middle third, in diseases of the organs contained in the abdominal cavity.—*The French Nurse.*

Indiana lays claim to the luckiest man on earth. He invented a flying machine which was broken to pieces at the first trial without killing him.

ABSTRACTS.

THE EVILS OF MARRIAGE AND PREGNANCY IN WOMEN WHO DO NOT POSSESS SOUND PELVIC ORGANS.*

A. E. AUST LAWRENCE, M.D., C.M., ABERD.†

In the first place, we have to consider the effect of marriage only, and secondly that of pregnancy occurring in these women.

This is the day of preventive medicine, and although I do not expect for one moment that medical men will ever have the power to veto the marriage of people, yet I am sure it is our duty to instruct the mothers of girls that there are much greater evils for them than remaining "old maids." If the family doctor would only warn these unsound people against marriage there would be far less misery in the world than there is. The fact is, there are numbers of women who marry, and yet are absolutely unable to lead a married life and can never become pregnant, and there are also a large number to whom pregnancy means a very great risk indeed.

No woman whose menstrual functions are not performed normally should marry, unless she has had a doctor's consent, and it has been considered that neither marriage nor pregnancy will intensify her trouble. Marriage has been a very common prescription for neurotic and hysterical women, without the slightest attempt being made to ascertain whether there is any real pelvic trouble to cause the symptoms complained of.

Women who suspect that they are wrong in the pelvic region will not consult a doctor as to whether they may marry or not, and they resent any opinion given that they are not as other women.

The first set of cases I wish to allude to is very common. If a woman, who

has had such an attack of pelvic inflammation as to leave the pelvic organs matted together and fixed, marries, she lights up again the old mischief. She has intense dyspareunia. If she becomes pregnant she frequently aborts. I have seen a large number of these women, some *before* marriage, have warned them (without any avail) not to marry, and have seen them *after* marriage when they were made very much worse. I have also seen these cases for the first time after marriage, and from the previous history have been convinced that there was mischief prior to marriage which had been made worse since.

In the present day it is the fashion to regard pelvic inflammatory attacks occurring in young married women to be the result of infection from the husband. My own cases do not bear out this to anything like the extent that is commonly supposed. Mothers ought to take a common-sense view of this question, and if their daughters' menstrual history is not normal, then the family doctor should be consulted. An examination of the pelvic organs sufficient for all purposes that I now advocate can be made through the rectum and abdominal wall, and I consider it ought to be made in all doubtful cases.

In cases of fibro-myoma of the uterus, the effect of marriage is not, as a rule, to intensify the condition that is abnormal, but sterility or repeated abortions are common and parturition is increased in its danger. In a certain proportion of these cases there are no symptoms whatever to lead the woman to suppose that anything is wrong, and it is only after some years of married life that she consults a doctor and finds that she is not likely to become pregnant. In

*From *The Bristol Medico-Chirurgical Journal*.

†Professor of Midwifery and Gynecology, University College, Bristol, and Physician-Accoucheur, Bristol General Hospital.

these cases there is no dyspareunia, and except for the sterility the conditions of married life are normal. I have no remedy to suggest for these cases.

In another set of these fibroid cases decided symptoms are produced, and I consider that these women ought not to marry: the menorrhagia and dysmenorrhea are both increased by married life, and if pregnancy takes place, abortion is very liable to ensue. There are, however, a certain number of fibroid cases where pregnancy occurs and goes on to its normal termination, a living child being born. I have attended nine women in their confinements who had large uterine fibro-myomata. One case I attended three times and one four times. All of these cases did well, and in one of them the result of repeated pregnancies was to cause total disappearance of the tumor of the uterus. The history was most instructive: at each pregnancy the uterine tumor increased in size; but during the involution of the uterus the tumor also underwent involution, reducing it considerably. Six months after the termination of the fourth pregnancy the tumor had entirely disappeared. Although this woman was cured of her uterine tumor by repeated pregnancies, I do not advocate this mode of treatment, and I should advise against marriage in any case of fibroid tumor of the uterus where the usual symptoms of that condition were present.

Where the fibroid tumor produces no symptoms and the contracting parties are made aware of the probability of a sterile life, then I see no reason to negative marriage. Each of these cases must be treated on its own merits, and we must bear in mind that the condition and position of the growth in the uterine wall may vary with time. I had under my care, for some five years, a patient with the growth in such a position as to cause profuse hemorrhage at the periods. By degrees this growth moved towards the peritoneal surface of the uterus, with the result of allowing the uterine mucosa to become healthy: the woman then conceived, and would have gone to her full time; but, not knowing she was pregnant, I passed a sound into her uterus and produced an

abortion. This case was very instructive, as the woman had regular monthly bleedings, no symptom of pregnancy, and a hard fibroid cervix; but she had two abdominal tumors at this visit, whereas six months before she had only one, and that one I had known of for years. Here the fibroid condition of the uterus masked the symptoms, and I suspected a second outgrowth from her uterus, or possibly an ovarian cystoma. The mistake I made was, in not using the stethoscope over the new tumor; for if I had, I should have heard the fetal heart, and then, possibly, I should have done on purpose what I did by accident, as the fibroid growth interfered with the uterus maintaining its normal axis in the pelvis, and I have no doubt that the induction of an abortion was less risky than letting her go on to her full time.

There is no doubt that pregnancy, complicated with a fibroid tumor of the uterus, is a very much more risky affair than under ordinary circumstances. We have, in addition to the mechanical obstacle often offered by the fibroid, to deal with a phase in the life-history of these growths which is most important to bear in mind, and that is their tendency to necrosis if their nutrition is interfered with.

This is a feature that all of us who have to treat these cases must always bear in mind. I have seen several women nearly die from septic changes occurring in the uterine tumor itself, due to its nutrition being interfered with in labor and sometimes due to direct injury in the confinement. I am sure the great point is managing a midwifery case, complicated with a fibroid uterus, is not to let the uterus become tired out, for if you do you will be sure to have to face a bad attack of *post-partum* hemorrhage: we all know how prone a tired uterus is to bleed under normal circumstances, and it is infinitely more so when it is the seat of a fibroid tumor which interferes with the mechanism of complete contraction and retraction of the uterine wall; besides, in these fibroid cases, you do not get the assistance from ergotin injections and the hot water douching, for the simple reason that the arrangement of the muscular fibres of the uterus is interfered with to a certain extent by the

presence of the fibroid growth. Bearing this in mind, always have at hand iron perchlorid to produce a mechanical stasis, when you are no longer able to obtain the normal physiologic process necessary for the arrest of hemorrhage.

The other evil of long-continued uterine action is the direct interference with the nutrition of the fibroid growth, and that this is no imaginary danger I can prove by several cases of sloughing of the fibroids *post partum*, as well as the production of a low form of septicemia, which is exceedingly difficult to treat and may require removal of the whole uterus to save the life of the patient. In all the cases I attended I cut short the labor as much as possible, and in all the fourteen labors I did not have any complications. The early use of the forceps is indicated in these cases if the vertex present, and manual assistance at an early date in other presentations.

The question of malignant disease of the uterus rarely complicates my subject, as it is not common at the ordinary age of marriage, and when present would of course be recognized as a distinct bar to marriage. There are cases of malignant disease of the uterus where the main symptom of increased loss of blood at the catamenial periods has been put down to other causes, and women have married not knowing their condition and have become pregnant, this latter state being an exceedingly grave complication. Yet if the point I contend for be granted, these cases ought to be recognized and marriage interdicted. We all know how patients with cancer of the uterus go on for a long time without seeing a doctor, but then, as a rule, the women are either married or spinsters with no idea of marriage. The early stages and history of malignant disease are pretty well known to medical men and should be attended to, and any woman contemplating marriage with such suspicious symptoms must be examined with the view of ascertaining what her real state is; and if the condition is suspicious, then a given time should be allowed to elapse to enable the doctor to say positively what the disease is.

There are other pelvic conditions which I think should absolutely bar marriage, and one is such deformity of

the pelvis that no living child can be born. Of course it is very easy to say that an abdominal section can be done and the child saved, but this mode of delivery is more serious to the mother than ordinary labor, and if she cannot bring forth her child in the natural way she should stand aside and let a more fortunate sister have her chance. Most of the women I have seen with such a deformed pelvis have become pregnant without going through the formality of marriage, and so no one had the opportunity of advising against it. I do not think that in the better classes a woman with such deformity of the pelvis would think of getting married; and if she did, would most likely consult a doctor before she took such a step, and then the question of pregnancy must be faced.

I now come to consider very briefly the remaining cases. No woman ought to marry with an ovarian tumor or broad ligament cyst, as the dangers of pregnancy are no doubt greatly increased. I do not think we are likely to have to give an opinion on the marriage question here: of course, if we did we must say that, until the operation for the removal of the tumor has been performed and we know what the state of the pelvic organs is after the operation, we cannot advise for or against marriage.

Several women from whom I have removed one ovary for cystic disease have married and had children, and there has been no loss of sexual capacity. Again, in some of my cases in which I have removed both ovaries in married women there has been no loss of sexual power: this fact is important in deciding whether a woman from whom both ovaries have been removed is pretty much in the same position as a woman who has ceased menstruating at the ordinary time of life. The very few cases I have seen have certainly led me to give the opinion that the only difference will be that there will be "no family," and that otherwise there is no reason to negative marriage. The various forms of tubal disease most frequently cause alterations in the menstrual life, producing pain and excessive hemorrhage, and if my advice is acted on the pelvic examination will reveal the disease and marriage must be vetoed.

There are many conditions which interfere with the due performance of the marriage contract, but most of them are brought to our notice after marriage and can be remedied. The great point is, to prevent women marrying in ignorance of such a condition as cannot be remedied but only made worse by marriage.

There is no doubt but that there are several chronic diseases that ought to act as a bar to marriage, some on account of the woman herself and some on account of her offspring, but this subject I cannot discuss now; nor can I open up the important subject of the effect of pregnancy in acute diseases, a subject of great importance.

DOMESTIC PRACTICE ON THE FRONTIER IN THE EARLY EIGHTIES.*

The recent commendation by a Russian surgeon of wood ashes as a dressing for surgical wounds, which he adopted after having seen it used by the peasantry, induces me to think that a few references to early domestic practice in this country may be of interest to some of the young doctors. Wood ashes were in common use in my boyhood days, and I have often used them on myself and companions when hunting and camping. The scab is not so firm as nature's blood scab, but if a little care is taken to prevent its premature removal, the scars show less plainly.

Among many African tribes, as well as among some of our Indian tribes, the man who can show a goodly number of large welts and callosities from self-inflicted wounds is accepted as brave. The manner of producing them is the same on both continents, and is by repeatedly stuffing the wound with wood ashes until a satisfactory amount of callus is formed. I have seen Indians whose bodies looked as if pieces of rope several inches long were imbedded in the skin, and of which they were very proud. Their production often occupies several moons, and they say that no Indian ever died while making them. It is commonly said the ashes are used to prevent quick healing of the wound. But many other things will do that.

I believe the man who invented the plan selected ashes because he knew that it was a perfect and always to be got antiseptic. As is the case with many other customs, the reason for it is forgotten, while the custom remains.

Ashes are a reliable cure for a running pole-evil. Clean and dry the fistula,

and then pack it full of ashes of recently burned corn cobs. Occasionally it may need to be repeated, but seldom more than once. It may be well to add that the ashes should be well tempered from the bottom of the fistula, and the horse then fastened by two halter straps so that the head cannot be got lower than the level of the shoulders for eight to twelve hours, and then turned out to graze, or at least be compelled to gather his food from the ground. The after-treatment should be such as he would use if his patient were a plantigrade.

The pioneer baby had the same sort of earache that the future baby will have, and had all the domestic remedies applied that the present baby does have. When these all failed to give relief, resort was had to what was called Dutch doctoring. This was to apply a poultice of hot fresh goose dung. The baby sometimes survived, and chronic ear disease followed just about as often as it does the treatment of the aural specialist of to-day. At one time I was inclined to think the Dutch got this prescription from the Slavs, for it is still in use among all the Slav people of Europe. But a few years ago it was found in ancient Egyptian papyrus, and I would not be at all surprised to learn that they got it from Chaldea, which was hoary with age when Egypt was an infant.

Writers upon *materia medica* tell us in effect, that ginseng root is only valuable to sell to the heathen Chinese. But the pioneers believed it to be a sovereign remedy for dyspepsia with flatulence. I shall always have a good word for ginseng, as for some years I used it from the time winter apples were gone, until

*T. R. Millard, M.D., in *Charlotte Medical Journal*.

the seeds in new apples become so firm they could not be mashed between my thumb and finger, when in place of ginseng root my pockets were daily filled with half grown apples, and during all these years dyspepsia was to me unknown. Could proof be more positive that it is a powerful preventer of dyspepsia?

Let no brilliant fourth year student imagine that those old pioneers were fools. They had one sense that we seem to have lost,—the sense to know when they had a good thing and to hold on to it until they got a better. In proof of this, a list of our indigenous remedies that did not fairly fight their way to official recognition by long domestic use is very short.

Warm or tepid sponge baths were much used in all sorts of fevers. General cold baths never. The bath was of white lye, *i. e.*, water to which ashes was added until it had a slippery feel. The use of ashes was not the only example that they appreciated as antiseptics.

The common treatment for carbuncles, and boils that did not readily shed their cores, was to place a cone of linen lint on the steel of an axe bit, ignite it and hold the steel of another axe bit over it until the lint consumed. Then a bit of lint of proper size was dipped in lard and as much of the lard pressed out as possible, and the lint made to take up as much of the burnt residue as possible, and then stuffed into the cavity, and the surrounding area was well blackened with the product of combustion. I do not know the complete chemistry of this residue, but its principal ingredients are carbon and pyro-ligneous acid. A pretty good antiseptic. At one time this was much used on cracked nipples, but about the close of the first quarter of the century some one brought to the frontier the plan of using egg oil, and it supplanted the old treatment. The completeness with which this has dropped out of use is another proof that we don't know enough to keep a good thing when we have it. There is but one better application, and that is composed of lanolin, ichthyol, etc.

My first taste of creosote reminded me so strongly of this old carbuncle remedy that I was ready to believe it of great

value, and this belief was strengthened while I was a student, by seeing Prof. Brainard, by its aid, secure complete cicatrization, after ulceration had so completely destroyed a nose that the ethmoid bone was plainly seen.

The first instrument I got, after getting my diploma, was a hypodermatic syringe. It had to be got from New York, and was the first one I ever saw. I regret that the fragments were not kept as a curiosity. No surgeon to-day would use its like, yet with it I got such reputation as a remote country doctor may get, by injecting creosote into carbuncles, just as the up-to-date surgeon injects carbolic acid. The acid has since been used, but I have never been sure that the result was better than was got with creosote. But it was new; it came from Europe, and was scientific, and, well, I always liked to know where the head of the procession was, even if I did not get there.

One of the recent suggestions of scientific writers is that physically the Americans are slowly developing likenesses to the Indians. The tendency of reversion to the type indigenous to the soil is matter of discussion among the learned, and American anthropologists have been slow to concede that we are growing like the red men. Parisian savants, however, taking unprejudiced views, are more favorable to the theory, and assume to have found anthropological statistics that support it. It is matter of common observation that American descendants of natives of other continents who come here are modified physically as well as intellectually by their environment, but the changes from various intermarriages and from differences of food and manner of life are so rapid, compared with the gradual changes that come from soil and climate, that these latter are apt to be overlooked. Let us watch the Southern negroes. They intermarry among themselves nowadays, and are not so much affected as they used to be by admixtures of white blood. If in the course of a few centuries they show a tendency to grow copper-colored and straight-haired, it will be an argument in the new theory's favor, and we may look to our own cheek-bones and noses.—*Harper's Weekly*.

SOCIETY REPORTS.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated meeting, January 13, 1897, the President, Dr. J. C. Wilson, in the Chair.

Dr. Thomas S. K. Morton demonstrated

A NUMBER OF APPLIANCES FOR ELECTRIC LIGHTING.

These consisted of several lamps permitting connection with the ordinary current as obtained from the street or from a storage battery. A head-lamp with a reflector was capable of giving, with a sixteen-candle-power incandescent loop, a light of fifty-candle-power, and was especially commendable for its lack of weight. It could be used for various operative purposes and by nurses and others on night duty in hospitals and elsewhere. It was also available for reading or other work of like character. The apparatus was provided with a neat, simple and satisfactory switch upon the right side of the head-band. The lamp itself was easily removable from its frame. Another light was enclosed in a small bulb of glass surrounded in turn by a second bulb, and between the two there flowed constantly a current of cool water supplied by means of two rubber reservoirs at different levels. By lowering one or the other reservoir alternately, keeping the one filled with water the higher, a constant current of water could be kept passing around the inner bulb, which in this way is kept constantly cool and can be introduced into any cavity of the body without causing pain or doing harm. An ordinary controller can be employed for governing the current, easily cutting it off when not needed and establishing the connection when the current is desired. The apparatus has been devised by Dr. Nevins, of Chicago. The manufacturers have also constructed a storage-battery weighing only fifteen pounds, capable of yielding a light of eight-candle-power for fifty hours.

Dr. T. S. K. Morton exhibited

A CASE OF EXCISION OF THE HEAD OF THE RADIUS FOR OLD DISLOCATION.

The case occurred in a woman, forty-two years old, who had been kicked by a horse some eight months before coming under observation. When seen, the head of the radius protruded prominently beneath the skin above and to the outer side of the joint, and extension and flexion and pronation and supination were greatly interfered with. There was much pain in the arm from pressure upon the musculo-spiral nerve and there were also pains referred to the distribution of other branches of the brachial plexus. It being evident that manipulation could not effect a reduction of the dislocation, excision of the head of the

radius was decided upon and carried out. The head was dissected free from its surroundings and cut off with a chisel above the attachment of the biceps tendon. The musculo-spiral nerve was involved in the adhesions and was set free before closing the incision. The wound healed by primary intention, and the result, surgically and functionally, was a perfect one. Complete power and perfect freedom of movement were restored, with relief of pain and without wasting, and ordinary examination was incapable of demonstrating any loss of bone, as the neck of the radius occupied the normal site of the head. The removed fragment exhibited erosion of the articular cartilage.

Dr. T. S. K. Morton exhibited also

A CASE OF VERY EXTENSIVE SKIN-GRAFTING AFTER THE METHOD OF THIERSCH.

A young man, twenty-six years of age, had the misfortune about a year ago, while walking in a boiler-room, to slip his left leg through an opening in the floor into a tank of boiling water. The member became caught in the tank, and remained in the water for a period of about thirty seconds before the man could be extricated by his companions. He was removed to the Polyclinic Hospital, and almost lost his life in the succeeding four weeks from exhaustion. The entire thickness of the skin sloughed from seven inches above the patella to the malleoli at the ankle, save a few small islets of epidermis, which remained upon the crest of the tibia. Before the sloughs had all come away, the leg had become flexed at a right angle with the thigh and was covered with very vascular granulation-tissue. At this time he was under the care of Dr. L. W. Steinbach, who, under ether, made forcible extension of the limb, and succeeded in bringing it out perfectly straight. The granulations, however, parted in the flexure of the knee-joint, and all of the ham-string tendons became exposed. Under the same anesthesia grafting with the skin of frogs was carried out. These grafts were placed upon the top of the granulations, but all failed to "take."

Some eight weeks after the accident Dr. Morton determined to apply extensive grafting after the method of Thiersch. The granulations were sterilized as well as possible by spraying with hydrogen dioxid diluted one-half with normal salt-solution (0.6 per cent. common salt in water), and were subsequently enveloped in gutta-percha tissue. When suppuration had been largely controlled by this method, a surface some ten inches long and two inches wide was scraped forcibly with a

curet. Bleeding was free, but was easily controlled by the binding on of sponges while the grafts were being cut. The skin of the opposite thigh, shaved and sterilized, was greased with a little boiled olive-oil. Then, with a razor ground flat on the under side and similarly greased, strips of skin were cut from its upper surface, the integument being held tense and slightly humped up by a hand above and one below the field from which the grafts were to be cut. These strips were cut about an inch wide and as long as possible. They much resembled wet tissue-paper. The razor was propelled by a gentle see-saw motion and not permitted to penetrate beneath the papillary layer of the skin. If fat is exposed it is proof that one has cut entirely too deeply; only the superficial layers of the skin are required. The grafts, as cut, heap themselves up in long strips upon the razor-blade. These are then transferred, right side down, directly upon the surface to be grafted, by seizing the end of the strip at the edge of the razor, bringing it to the edge of the wound, and then gently drawing the razor away from this point in the direction of the surface that the graft is meant to cover.

If it is more convenient to cut a large number of grafts before beginning to apply them to the wound, they may be temporarily placed in a bowl of the warm salt-solution. It is essential that no antiseptics be used during the entire process of grafting and dressing, as such chemicals destroy the delicate cells of the grafts. Salt-solution alone should be used as an irrigant.

When the wound to be grafted has been gently covered with the strips of skin, slightly overlapping each other in all directions, the entire area is roofed over with strips of Lister protective or gutta-percha tissue, and a copious dressing of gauze wet with salt-solution placed outside. Over the whole a sheet of gutta-percha tissue is wrapped, and finally a wet gauze bandage is applied with moderate firmness.

All bleeding must be stopped before the grafts are applied. Prior to placing the dressing, the grafts must be gone over with some flat instrument, like a spatula, in order that air-bubbles, blood-clots, or whatever might prevent contact of the grafts with the wound-surface, may be squeezed out. The dressing is kept wet with salt-solution for forty-eight hours, when re-dressing should be done, and the surface sprayed gently with hydrogen dioxide in salt-solution (half and half), washed off with salt-solution and dressed as at first, save that now it is not necessary that the gauze should be kept wet.

By this process of Thiersch, repeated some dozen times in the course of a year by Dr. Morton and his colleagues, Drs. Roberts and Stern, the entire area of burn was gradually obliterated, so that now a true skin covers the whole area that sloughed away. It is even movable freely over the underlying tissues at all points and much elastic tissue has developed, so that upon the thigh and calf the skin

can be raised an inch from the underlying surfaces. As no hair, fat, or sweat-glands are present in the transplanted skin, it is necessary for the patient to daily anoint the parts with a little purified lanolin or other unguent to prevent drying and cracking of the epidermis. Sensation has returned completely throughout the new skin. There is no contraction at the flexure of the knee-joint or elsewhere, and, so far as appearances go, the leg is in perfect condition. The surfaces from which the large quantity of grafts were derived comprised the opposite thigh, the thigh upon the injured side above the burn, and both upper arms. These regions, especially the thigh, were able to yield successive crops of grafts at intervals of about six weeks, and at present appear to be in normal condition, save for slight discolorations. The hair is growing over them all as usual, proving that only superficial layers of skin were taken away. The surfaces healed over, as a rule, after taking grafts, in about two weeks. These raw surfaces were covered by strips of protective and a dry gauze dressing and bandage. Simple dusting with formaldehyd-gelatin, without other dressing, has also proved satisfactory.

Dr. Morton remarked further that this was the largest surface that he had ever attempted to graft, and the greatest area that had ever been successfully covered so far as he knew. The result proved that even extensive girdling ulcers of an extremity resulting from burn or other injuries present no insurmountable barriers to full healing. The case further demonstrated that great losses of integument can be repaired without being followed by disabling, painful, or unsightly contractions. Dr. Morton believes that no large granulating surface should be permitted to close spontaneously, if by such healing contractions are liable to take place, for by the use of Thiersch grafts such results can usually be prevented.

Dr. J. K. YOUNG said that it had been his privilege to see the patient in consultation with Dr. Morton and several other surgeons, and he viewed the result as in every way gratifying. At the time of the consultation there was a difference of opinion as to what was the preferable measure under the circumstances, and it was finally decided that grafting of skin by the Thiersch method should be tried. From personal observation in Rupprecht's Clinic, in Dresden, Saxony, Dr. Young was confident of the utility of this method, and he recommended the application to the wounds after the grafts had been applied by being washed off from the razor the dusting of a powder, consisting of equal parts of talcum, boric acid and zinc oxid.

Dr. ERNEST LAPLACE said that the case demonstrated the superiority of the Thiersch method of grafting over other methods formerly in vogue. All that is required to check the granulating process is isolation of the surface from the air by means of epithelium, and this end is effected by means of the grafts.

The case illustrates further what care and attention to detail and the correct application of true pathologic principles are capable of accomplishing.

DR. J. P. MANN read a paper

CONCERNING THE TREATMENT OF CLUB-FOOT.

(See p. 161).

DISCUSSION.

DR. DE FOREST WILLARD said that he agreed with nearly all of the conclusions with regard to subcutaneous tenotomy and forcible stretching. These are usually sufficient to secure a proper position of the foot, and if followed by appropriate mechanical treatment for a number of years, they will result in a useful, flexible foot. The walking results will be satisfactory, even though there remain some inturning of the metatarsus in its relation to the tarsus. If the original deformity has been permitted to continue uninterfered with for ten or fifteen years, it becomes almost impossible to correct this obliquity by any manipulation save that of extreme force. In many cases there is actual dislocation and overlapping of adjacent metatarsal bones, as can be shown by a skiagraph. Under these circumstances it is impossible to entirely overcome the internal deviation. Internal rotation at the knees and hips also takes place, which will require much muscular practice to overcome.

When club-foot exists at birth manipulation should be begun at once. If the bones are permitted to grow in their abnormal shape during the first month of life a golden opportunity is lost.

In Dr. Willard's opinion the age for operation should be earlier than that fixed by Dr. Mann, viz.: rectification should be secured as soon as the child shows any tendency to walk, say from the ninth to the twelfth month, rather than after he begins to walk, say from the twelfth to the eighteenth month, as recommended by Dr. Mann. By bringing the foot into proper position the weight of the body assists in bringing about the cure. A child should never be permitted to walk with its feet in improper position.

Dr. Willard is disposed to avoid mutilating operations whenever possible, but when it becomes necessary he has no hesitancy in removing some portion of the tarsal arch. The surrounding conditions of the patient, as well as the condition of the feet, have something to do with the decision. For instance, in the case of a child from the country, untreated for a period of five, eight or ten years, whose parents take little interest in its welfare, if a partial cure only were secured the probability is strong that the child would return home and suffer an early relapse. Circumstances like these justify the placing of the foot in such a position that carelessness on the part of the parents or of the patient could not lead to an unsuccessful result or relapse, and removal of the astragalus would be allowable when it

might not otherwise seem to be demanded. Even in adults tenotomy will often yield good results, but when a speedy cure is desired bone-operations are imperative in a certain number of selected cases. Under conditions like those already mentioned operation is not only justifiable but even necessary. With these exceptions multiple tenotomies, mechanical treatment, and forcible correction will ordinarily prove sufficient.

Dr. Willard rarely performs the same operation twice in succession, as each individual case requires the application of specific and definite means to accomplish a desired rectification.

DR. J. K. YOUNG agreed in many details with what Dr. Mann had said, but he took exception to others. He was misquoted as not approving of operation; for, while formerly having some doubt in the matter, he had come to look more favorably upon surgical interference and had performed all the accepted operations a sufficient number of times to decide their relative points. If manipulation is begun at birth operation will often be unnecessary; should it still be required it can be deferred to the age of six or twelve months. Multiple tenotomy is the operation of first choice when such interference is indicated. If it proves insufficient Phelps' operation is the next resort, astragalectomy is the third choice and tarsectomy the fourth. Dr. Young desired to retract some remarks he has made on several occasions against the justifiability of tarsectomy since he had met a case (the photograph of the cured condition of which he exhibited) in which this operation was not only justifiable but necessary. Such cases are exceedingly rare. After operation by tenotomy it is not necessary to remove the plaster before the expiration of two weeks. After the Phelps' operation, in case the blood-clot of Schede is availed of, the dressing may be left unchanged for five or six weeks. Then, if the technic has been perfect, healing will be complete. The treatment after operation is quite as important as that before, and various forms of apparatus may become necessary. Apparatus may be sufficient in many cases without operation, but not in all. If a cure is not effected within one year by manipulation and appliances, operation should be resorted to.

DR. G. G. DAVIS pointed out that each case must be treated according to its specific indications. If a child's foot cannot be brought into a correct position by manipulation there can be no objection to tenotomy. Before the child has begun to walk manipulation, accompanied by splints, will usually bring about a cure without operation, but no evil will result from division of the Achilles tendon. This measure shortens and renders the treatment easier. As the child grows older it becomes less amenable to manipulative treatment. From the time it begins to walk to the period when the bones are hardened, say to the twelfth year, something more positive is often required in addition to simple splints

or apparatus. At this time plaster of Paris is useful. After the tendons have been divided the foot is stretched to its utmost and fixed with plaster of Paris in its corrected position. The stretching may be repeated in the course of ten days and the dressing renewed; this may be done several times. When the foot has been brought into proper position it must be retained there by appropriate apparatus.

As the bones grow harder, sometimes it becomes impossible to straighten them, even by the means last named. The bones of the foot become distorted, the neck of the astragalus being bent inward; the foot is often turned inward at a right angle to its natural position, and even the contracted skin offers resistance to replacement by manipulation. Under these circumstances crushing appliances have been employed, but their use is rarely desirable. By grasping the foot with wet towels a very great amount of force can be exerted to twist the member into place. In case stretching and plaster of Paris fail, the next available measure is a matter for discussion. Dr. Davis has found that in cases in which Phelps' operation, or astragalectomy, seemed indicated he was eventually able to succeed without resorting to either. Tenotomy, fixation with plaster of Paris and subsequent mechanical appliances usually sufficed. In failure of these recourse was had at once to resection of the tarsus. In several cases of this kind previously reported the results had been admirable. Some cases will yield only to radical correction; conservatism will entirely fail to relieve the pain and correct the deformity. In these severe cases the mere removal of the astragalus will not alone effect a cure. The tendency to relapse will remain. It will be necessary to divide the remaining portion of the tarsal arch. The practical end to be attained must always be kept in view. In the cases of the poor, the careless, the inattentive, in all those that cannot be kept under careful observation for considerable lengths of time, it becomes necessary to institute a form of treatment that will secure the desired result as speedily as possible, and more radical measures are allowable than would otherwise be the case.

DR. T. S. K. MORTON expressed gratification at the emphasis that had been placed upon the rejection of operation immediately or soon after birth. Such operations are likely to do more harm than good. At the same time, fourteen months seems a long period to routinely delay operation. The best time would appear to be when the child begins to manifest a desire or ability to walk. Subsequent to this period there is the advantage of the weight of the child standing and walking upon the corrected feet supported by braces, making the thrusts and strains take the proper direction. The statement that all cases of club-foot are capable of correction by manipulation of simple division of soft parts seems rather too broad. In cases that can be kept under observation from birth, correction can always be

so effected. When, however, marked bony deformity exists, excision of bone becomes necessary. It is best in such cases, first, to excise the astragalus, and if then full correction be not established, to go on taking away portions of tarsus until the deformity is relieved. The records at the Orthopedic Hospital show the splendid results of this plan of procedure, which has been pursued for a period of some eleven years. The statement that it is "criminal" ever to cut bone, even in adults, for the correction of club-foot, is, to say the least, reckless. After resection has been practised the subsequent result depends largely upon the after-treatment—even more so, perhaps, than after tenotomy. The use of plaster of Paris is not entirely safe, and the recommendation to other than experts, to maintain forcible over-correction, is not free from danger. Unless this dressing be changed frequently there is considerable risk of sloughing and like complications from too severe pressure upon the defectively nourished tissues that invariably go with club-foot.

DR. ERNEST LAPLACE said that, while always preferring to be conservative, it is impossible to make any rule in the treatment of club-foot that will be applicable to all cases. Some cannot be corrected by mechanical treatment and manipulation, and in these it will become necessary to do an operation on the bones. The personal equation must necessarily enter into the decision in each case.

DR. J. P. MANN referred to a very stubborn case of double congenital equino-varus in a young woman, twenty-five years old, in which by means of subcutaneous section of the soft parts, leverage, and plaster-of-Paris dressings it was possible for the patient to walk flat upon the soles of her feet. The plaster casts made at different times in the progress of the case, show the marked improvement that had been wrought. To effect such a result required, of course, much time and several operations, but the patient was willing to submit to the treatment.

While not contending that there are no cases requiring operation on bone, Dr. Mann stated that it has been his fortune in an experience of ten years not to have encountered any. He quoted from the published opinions of forty leading orthopedic and general surgeons, who declared themselves not in favor of the removal of bone to correct club-foot.

When apparatus is required, the simpler in construction the better, as many of the cases are among the poor and unintelligent, and the use of a complicated apparatus may invite relapse.

In case of simple equinus the first and only structure to divide is the tendo Achilles, after mechanical measures have failed; but if the deformity is compound such division should be reserved to the last, as the tendon must be despoiled upon to afford a point of resistance in the various manipulations made in correcting the tarsal deformity. After the deformity has been entirely overcome the tendon may be

divided. The tendo Achilles also, before it is severed, exercises the function of protecting the ankle-joint during tarsal correction.

After a certain age the tarsal bones become deformed, and it is realized that they are not made normal by pressure and tenotomy; but they are so molded as to permit the foot to assume its proper position.

Dr. Mann believed in persisting in mechanical treatment from birth to the time when the child begins to walk, feeling that the worst deformities do not yield as good results if operated on before this period as if operated on afterward. Perhaps 90 per cent. of the 500

cases treated by Dr. Mann occurred in poor patients and those living out of the city; yet it was not necessary to keep them in the hospital more than two months. Relapses were few, and these were due to neglect.

Dr. Mann in a long experience has seen no bad effects from the use of plaster-of-Paris dressings. Of course, these are to be applied by a competent individual, and students must be carefully instructed in the mode of application. No particular rule can be laid down for the treatment of any case. Some cases are cured by mechanical treatment, without operation. Others may require operative interference.

PERISCOPE.

Formulae.

FOR EPITHELIOMATA OF SLIGHT EXTENT:

Resorcin	3ss
Pot. chlor.	3ijss
Aque. dest	3x

M. Sig.—Apply frequently as a wash.—BROCC.

FOR BURNS OF THE SECOND DEGREE:

Calcis. carb	3ijss
Zinci. oxid	3j 9ss
Amyli,	
Ol. lini,	
Aq. calcis	aa 3ijss
Ichthyol	9ss to 9ijss

LEISTKOW.

FOR VAGINISMUS:

Strontii bromid.,	
Potass. bromid.,	
Ammon. bromid	aa 3i
Aq. destill	3viij

M. Sig.—Tablespoonful twice a day.

Or,

Zinci valerianat	gr. $\frac{5}{8}$
Quinin. valerianat	gr. jss
Extr. opii,	
Extr. belladonn	aa gr. $\frac{1}{8}$

M. ft. pil. no. j.

Sig.—From 3 to 6 pills daily.

Locally,

Ext. kramerise	gr. iss
Morphin. hydrochlor	gr. $\frac{1}{4}$
Ol. theobrom	3j

Ft. suppos. vaginal.

Or,

Cocain. hydrochlor	gr. iij
Ext. belladonn	gr. ijs
Strontii bromid	gr. iv
Ol. theobrom	3ij

M. ft. suppositor. vaginal.

TOUVENAIN in *New Yorker Med. Monatschrift*.

FOR VEGETATIONS OF THE VULVA:

Powdered savine,	
Desiccated alum	aa 25 parts.
Corrosive sublimate	1 part.—M.

A more active application is the following:

Powdered savine,	
Iodoform,	
Salicylic acid	aa equal parts.—M.

LUTAUD in *Tri-State Medical Journal*.

FOR CORYZA:

Ac. carbol.,	
Aq. ammonise	aa 3jss
Alcohol	3iij
Aque	3iv

M. Sig.—Ten drops let fall on blotting paper and inhale through the nose.

Or,

Cocaini	gr. v
Menthol	gr. iv
Salol	3jss
Ac. boric	3iij

M. Sig.—Use as a snuff.

Or,

Cocaini	gr. v
Menthol	gr. ij
Bismuth salicyl.,	
Sacch. lac	aa 3j

M. Sig.—Use as snuff.—LERMOYEZ in *Practitioner*.

FOR CHAPPED HANDS AND FACE AND SORE NIPPLES:

Compound tincture of benzoin	10 mm.
Alcohol	3ij
Aque rose	30 mm.
Glycerin	3j

Mix. Apply to chapped surfaces at night, after washing with soap and water and carefully drying.

FOR MENTAL DEPRESSION IN PELVIC DISEASE:

℞ Strychn. sulph	1 gr.
Quinin. sulph	1 gr.
Ext. hyoscyamus	1 gr.
Ferri. redactum	gr. j

Mix.—For one pill. Dose, one pill thrice daily.

—DR. TALLEY.

FOR LARGE ACNE PUSTULES:

Ichthyol	1 part.
Bismuth subnitrate	1 part.
White precipitate	1 part.
Vaseline	10 parts.

Apply at night.—VON HEBRA AND ULLMAN.

FOR TOOTHACHE:

℞ Camphor. vas,	
Chloral hydrat	āā gr. lxxv
Cocaini hydrochlor	gr. xv

M. Sig.—To be introduced into the tooth-cavity.

℞ Cocaini hydrochlor	gr. xv
Opii	gr. lx
Menthol	gr. xv
Althææ pulv	gr. xlv

M. Div. in pellets weighing one-half grain each. Sig.—Place a pellet in cavity of the aching tooth.

℞ Lini aconiti . . . (B.P.)	
Chloroformi	āā f3ij
Tr. capsici	f3j
Tr. pyrethri,	
Ol caryophylli,	
Pulv. camphoræ	āā 3ss

M. Sig.—A few drops on cotton to be placed in the cavity.

NEWS AND MISCELLANY.

The Obstetric and Gynecologic Section of the Buffalo Academy of Medicine held its regular meeting January 26. Program: "Résumé of Fifty Years Obstetric Practice," Dr. John Hauenstein.

The physicians, druggists and dentists of Maine want a State prosecuting agent to see to the enforcement of the laws applying to medicine, pharmacy and dentistry. The bill that aims at the establishing of such an office was drawn up by Dr. F. Hanson. The Boston Herald says:

"The first section of this bill provides for the appointment by the Governor of an officer who shall be the prosecuting agent for the State in cases of infraction of medical, dental and pharmaceutical laws. He shall serve for a term of four years. It shall be the agent's duty to investigate all violations of the laws

pertaining to these professions, and he shall prosecute all offenders against these laws. He shall have the power to call upon the several county attorneys and the Attorney-General for aid in prosecuting offenders, and shall himself be possessed of all the powers delegated to the sheriffs of the various counties. He may serve writs and make arrests, and shall also have the power of a coroner. For his services he shall receive no direct compensation, but shall be paid in fines collected."

If this bill passes in Maine and works well, it would be a good idea for other States to imitate.—*American Medico-Surgical Bulletin*.

The incompatibility of antipyrine and calomel is considered by Dr. H. Werner (*Pharmaceutische Zeitung; Wiener klinische Rundschau*, October 11, 1896,) and he gives a caution against the simultaneous use of these two drugs. Their reaction results, he says, in the formation of a dangerous amount of corrosive sublimate even when ordinary medicinal doses are given.—*New York Medical Journal*.

In Alameda, Cal., they have adopted the novel plan of saturating the meat of diseased cows with kerosene oil after being condemned by the Board of Health. This keeps the boneyard men from selling it to butchers for use as food. A gallon of common kerosene is pumped into the carotid artery after killing, by means of a Davis pump.—*Medical News*.

A case where the larvæ of flies were a cause of chronic pseudo-membranous enteritis is reported in the *Wien. Kl. Rund.*, in which a man drank out of a brook, and, after some weeks, suffered from diarrhea, with mucous stools. After long suffering, a microscopic examination revealed the presence of hundreds of larvæ of a kind of fly allied to the common house-fly. Suitable treatment soon relieved the condition, but it is interesting to note that our domestic pests may be the source of serious trouble.—*Med. Press*.

Statistics show that a first attack of consumption is not always fatal, and death is often found to be due to other causes. Primary infection is not usually due to inherited tendencies, but external conditions play a most important part. Consumption is best treated among the rich; frequently, indeed, a permanent cure is effected in this class of cases; so, for evident reasons, those who are poor should be given especial attention. Patients who have been cured must not be allowed to return to their former environment. Redevelopment is inconsistent with clinical experience. Change of air and outdoor exercise and labor hardens and refreshes the tissues, and the respiratory impurities of former environment are no longer present. Reinfection may be prevented by thorough disinfection.

tion of the patient and surroundings, and destruction of the sputum. This protects the patient against himself.—JOSEPH MUIR, M. D., *Medical News*.

Notes on the treatment of fecal fistulae by Dr. Frederick Holme Wiggin in the *Medical Record* apparently shows the chief cause of the occurrence of fecal fistula to be the delay in resorting to operative measures to which patients suffering from typhlo-enteritis, or strangulated hernia were frequently subjected while their ailment was carefully diagnosed. The view recently advanced by a writer on the subject under consideration, that the best treatment for this condition consisted in its prevention, was concurred in. But in the case in which this mishap had occurred, it was pointed out that if the opening was of small size, was located near or below the ileo-cecal valve and no obstruction to the fecal current existed, operative measures might be deferred, as in most instances the opening would close in a short time spontaneously. On the other hand, if the bowel opening was of large size, was situated laterally, or some distance above the ileo-cecal valve, and was accompanied by the escape of a large proportion of the contents of the bowel, operative procedure for the closure of the opening should be speedily undertaken. The occurrence of the fistulous opening was due in the first case to failure, and in the second case, to delay in resorting to surgical treatment of typhlo-enteritis, from which disease both patients originally suffered. In the third case, the bowel opening was caused either by the pressure of the gauze used to drain the abscess cavity, or by an ulcerative process which originated from within the gut. In the first case, as the opening in the bowel was of large size, irregular in shape, and the gut was thickened and friable, the diseased portion of bowel containing the opening, about four inches in length, was excised, and the divided ends joined by the suture method of Maunsell. In the second and third cases, the bowel openings were situated in the head of the colon, and were in both instances closed by means of several rows of sutures, after which the omentum was drawn over the former site of the fistula, and retained in position by sutures. In describing the technic employed, the writer laid much stress upon the thorough disinfection of the parts, including the interior of the bowel, with hydrozone, the closing of the intestinal opening, when possible, before the breaking up of the peritoneal adhesions, and the opening of the general cavity, the removal of any existing obstruction to the fecal current, the disinfection of the bowel surface with a solution of hydrozone, before and after the placing of the sutures, the control of oozing from the cicatricial tissue by the same means and the closure by a single row of silk-worm gut sutures without drainage of the abdominal wound after the washing of the peritoneal

cavity with saline solution, some of which is allowed to remain. Ever since September, 1893, when he had proved the value of hydrogen dioxide as an effective antiseptic, which in proper solution did not unduly irritate the peritoneum, when followed by a six-tenths per cent. saline solution, he had had little reason to fear the danger of causing septic peritonitis from the accidental escape of pus or fecal matter while operating; and that when this complication had occurred, it had been invariably successfully met by the use of hydrogen dioxide in the manner described in the paper. He advised the excision of the diseased portion of the gut in those instances where it had become much thickened and friable, and expressed the belief that with a clearer understanding of the objects to be attained by operation—i. e. the restoration of the integrity of the intestinal canal, as well as the closure of the opening in the bowel—future operations for the cure of fecal fistula would more frequently result successfully than they had in the past.

Some points of interest in registration of physicians in Massachusetts.—Chapter 230 of the Massachusetts laws, passed in 1896, provides that all applications for registration as physicians or surgeons under the provisions of chapter 458 of the acts of 1894, shall be made upon blanks to be furnished by the board of registration in medicine, and shall be signed and sworn to by the applicants. It further requires that such board shall examine all applicants, and only such as are found qualified and shall give satisfactory proof of being twenty-one years of age and of good moral character shall receive certificates of registration as provided in said act: provided, however, that said board shall register without examination any applicant whom it may find to be of good moral character, of more than sixty years of age, and a graduate of a generally chartered medical college having power to confer degrees in medicine, and who has been a practitioner of medicine in the commonwealth of Massachusetts for a period of ten years next prior to the passage of this act (which was approved April 1, 1896), and who otherwise complies with the provisions of this act. Said board may, by unanimous vote, after a hearing, revoke any certificate issued by it to, and cancel the registration of, any person convicted of any crime in the practice of his professional business, or convicted of a felony. Any person who shall practice medicine or surgery under a false or assumed name, or under a name other than that under which he is registered, or shall personate another practitioner of a like or different name, shall be punished by a fine of not less than one hundred dollars nor more than five hundred dollars for each offense, or by imprisonment in jail three months, or by both.

—*Jour. Amer. Med. Ass'n.*

Hysteria.—That a favorable prognosis is not always safe in hysteria has been shown

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by Fournier and Sollier (*Jour. de Med.*). In some cases expectant treatment will not answer. Death may occur from spasm of the glottis. Fournier had a case with severe asphyxia in a young woman of twenty that was saved by faradism, but who afterwards had another attack, in which she died. Where there are laryngeal manifestations in hysteria it is not safe to leave the patient to herself. Potain had a case of hysterical angina pectoris that died, and the post-mortem revealed nothing to account for the fatal result. In hysterical anorexia, death also has been known to occur, even where artificial feeding has been resorted to. The system in such cases seems to have no power of absorption. Vaginal hysterectomy is particularly dangerous in such cases.

It is quite possible that in due course of time the question of whether aphasia constitutes a legal disability in the case of a patient making a will, will be brought forward for decision. Dr. Mantle, of Halifax, has just recorded a case in which an aphasic patient of his made a last will and testament under certainly unusual circumstances. The patient formed the outline of the letters on the bed-sheet with his finger, and then explained to his solicitor and wife that when they meant "yes" they were to squeeze his hand, and when they meant "no" to tap it. In this manner the testator was able to have his wishes incorporated in a will, which he subsequently signed with his left hand. Of course the point upon which the legality of the document will depend is, whether there is sufficient evidence to show that the mental condition of the patient was satisfactory at the time that the will was drawn up and signed. As such point has never been raised before, the matter is one of no little interest.—*The Medical Press*.

It has long been suspected that salt used in excess might be a cause of nephritis. The kidneys are taxed to eliminate a portion of it, and the strain, if kept up a long time, is more than they are able to bear. Some studies recently made seem to confirm this opinion. That is to say, too large an amount of common salt in our food acts as an irritant, and may be one of the factors in causing inflammation of the kidneys. Those who take this condiment in large quantities should bear this in mind and take less of it. The salt habit is so strong in many persons that they can enjoy no food not highly seasoned with it. This is certainly a hygienic error. With a well-chosen diet, no great amount of salt is required, and the natural flavor of many things is lost when much of it is added. Especially is little salt required when a large amount of flesh is consumed. Carnivorous animals do not require salt at all. There are races of men who live mainly on animal food, and though salt abounds around them they do not use it.

It is the vegetable-eating animals and races of men that seem to require salt as a part of their diet. Bearing this in mind, we ought to be able to compose our food and condiments more scientifically.—*Charlotte Med. Jour.*

The Public Health Act of 1896 came into operation on November 9th, finally abolishing the last remnant of quarantine which was maintained against yellow fever and plague in order to secure the commerce of Great Britain against unnecessary restrictions in foreign ports. This change transfers the control of yellow fever and plague in ports from the Privy Council to the Local Government Boards of the three divisions of the kingdom. The Local Government Board has issued an order embodying their regulations regarding yellow fever, plague and cholera, the preventive measures concerning the two former diseases being practically the same as those which have been successful in the prevention of cholera. No difficulty is anticipated with foreign nations from the change. In the opinion of the *Lancet*, most nations have come to realize that British methods of dealing with cholera in its own ports are really as effectual as theirs. It is noted that unless ships supposed to be infected with yellow fever or plague happened to select the Solent for purposes of arrival the usual port authorities would deal with the matter, having done so, in fact, as regards yellow fever. The *Lancet* also wishes that the same abandonment of antiquated forms would be observed regarding the crown colonies of the Mediterranean, for which the advisers to the crown are responsible. It is hoped that soon local legislators of these colonies will learn that the best measures for prevention of disease are found in sanitary improvements, and that too implicit trust in quarantine restrictions avoids the strongest incentive to expenditure in measures for the promotion of public health.—*International Medical Magazine*.

The East Anglian Branch of the British Medical Association has placed Mrs. Garrett Anderson in its Presidential Chair. Those who can recollect the effervescence of conservative indignation which was evolved not very many years ago, when it was first proposed to allow a female even to be a Member of the Association, and those who can look back upon the triumphal progress of the medical Amazons through universities and colleges, and have observed the firm and determined tread with which they have marched over all obstacles, will be very certain that the victory is theirs, and that resistance, collective or individual, is useless. It may be that the next century will see a female physician elevated, as a successor to Lord Lister, to occupy a Peeress's seat in the House of Lords (and Ladies).—*The Medical Press*.

Meetings of the Philadelphia Medical Societies.

- Academy of Surgery,
First Monday of month, October to June.
- College of Physicians,
First Wednesday of month, October to June.
- Section on General Medicine,
Fourth Tuesday of month, from September to May.*
- Section on Gynecology,
Third Thursday of month, October to June.
- Section on Ophthalmology,
Third Tuesday in month, September to May.
- Section on Otology and Laryngology,
First Tuesday of month, October to June.
- Section of General Surgery,
Second Friday of month, October to May.
- Philadelphia County Medical Society,
Second and Fourth Wednesdays of the month, September to June.
- Neurological Society,
Fourth Monday of month, October to April.
- Northern Medical Association,
Second and Fourth Fridays of month, September to June.
- Obstetrical Society,
First Thursday of month, September to June.
- Pathological Society,
Second and Fourth Thursdays of month, September to June.
- Pediatric Society,
Second Tuesday of month, October to June.

* Subject to change.

Lactophenin in Typhoid Fever.—Dr Beverly Drake Harrison, of Sault de Ste. Marie, Mich., relates his experience with typhoid (500 cases with only two deaths) and explains his treatment.

His treatment consists of *drainage, disinfection and diet*. He gives calomel and citrate magnesia water, washes out the rectum and lower bowel with normal salt solution, orders an antiseptic mouth wash, lithia water, intestinal antiseptics, etc., and gives careful attention to the diet.

He says (*The Physician and Surgeon*), Nov., 1896: "To eliminate the toxins and to promote skin drainage I prescribe the antipyretic, lactophenin, which is allied chemically and therapeutically to phenacetin, lactic taking the place of acetic acid. It acts like phenacetin, but more slowly, has a more calming and hypnotic effect, with no effect upon the heart except that the pulse becomes fuller and slower, while the breathing is unaffected. A moderate dose, five to ten grains, is given every second hour if the temperature rises

above 102° F., until perspiration is produced. The dose and frequency of its requirement is diminished as the case goes along. The temperature is seldom, if ever, reduced below 100° F. by its action, and the reduction is gradual, occupying three or four hours. I cannot speak too highly of lactophenin as an antipyretic and hypnotic. I have used it altogether in my practice during the past three years to the exclusion of all other antipyretics, and I have yet to learn of a single case in which it had the slightest depressing effect upon the heart or circulation. I also regard it as a valuable toxin neutralizer, as it will reduce temperature at 100° F. one or two degrees without causing perspiration. In treating moderate cases of typhoid, I have, on several occasions, discontinued the lactophenin in order to watch the effect of intestinal antiseptic treatment alone, but have been forced to renew the antipyretic at the earnest solicitation of the patients, who complained that they were not doing as well, and that the only time they had any peace was after taking a 'sweating powder.' "

The report is valuable, considering the excellent record of success, and the treatment described may be followed in general practice with hope of best results.

Contagious impetigo, according to William S. Gottheil, M.D. (*Pediatrics*, October, 1896.), is a self-limited contagious disease of children appearing in localized epidemics, and first described by Tilbury Fox in 1864. Accompanied by a moderate fever and some gastric disturbance, there appears on the face and hands groups of flat vesicles filled with transparent or cloudy serum. These dry up into characteristic golden-yellow crusts, which fall off in two or three weeks, leaving circular, reddened, non-ulcerated areas behind. Successive crops of vesicles may prolong the disease for two months or more. It is undoubtedly parasitic; but, though Kaposi claims to have found it, the etiologic factor is still not positively known. The treatment consists in removal of the crusts with olive oil compresses, cleansing the skin with hot water and soap, boric acid solution, etc., followed by the use of Lassar's paste:

Acid. salicylic	30 grains.
Petrolati	1 ounce.
Zinci oxidi	
Amyli	aa ½ ounce.

Record used to say, concerning the preparations of gold that certain practitioners had substituted for mercury as specifics in syphilitic diseases, that, everything else being equal, they produced better results when administered by the patient to the doctor than by the physician to the patient.—*N. O. Med. and Surg. Journal*.